Dear Insurance Professional:

Respect. One word. *Webster’s* definition reads:

*noun \ri-ˈspekt\*

: a feeling of admiring someone or something that is good, valuable, important, etc.

: a feeling or understanding that someone or something is important, serious, etc., and should be treated in an appropriate way.

: a particular way of thinking about or looking at something.

Perhaps more than any other word in our language, this word represents the crossroads where we stand both as a nation and for those of us in this profession.

From the streets of Ferguson, Missouri to the halls of Congress and stretching from our courtrooms to our board rooms, we have lost sight of this single word. America did not begin as a strong and organized nation. The greatest country this world has ever seen began when individuals took personal responsibility to step up, seek justice and strive for a better future. Those individuals banded together in a spirit of unity and determination and changed the world.

In three decades I have seen the practice of law change as well as the relationship between insurers and their counsel. Neither for the better. Civility is a form of respect. All of us entrusted with the privilege and honor to represent individuals and corporations in legal matters must do so in accordance with these basic principles. The rise of spurious class action cases, unreasonable “time limit” demands and growing medical, body shop and even lawyer fraud disrespects every person and profession impacted by these actions.

In like manner, many insurers no longer view their own counsel as a friend and partner but merely a “service provider”. What for decades was a bond of mutual trust and appreciation has become nothing more than a vendor relationship seeking the lowest expense based on a “metric” analysis. Why? In equal part the answer is insurance lawyers who for years abused this trust for profit, and insurers who in turn fail to recognize their legal counsel as a vital part of the Claims Services Team.

This year we begin our second quarter-century of service to the insurance industry. We will not win every case, satisfy every judge or client, nor ever claim we are the best. What we pledge is to honor and respect you, your company and the insureds you give us the privilege to represent. It is a foundation upon which not only our Firm was founded, but our Country was established upon more than two centuries ago. More importantly it is a pathway for us to follow. Whether that path leads to a successful outcome in an insurance investigation or lawsuit, to restoring relationships so we value each other as equal citizens, or in requiring our elected leaders to work together for our common good, the first step will always simply be… RESPECT.

With gratitude and best wishes from all of us,

Matthew J. Smith  
President
# TABLE OF CONTENTS

I. OFFERS OF JUDGMENT: STATE-BY-STATE SUMMARY ................................................................. 1

II. STATUTES OF LIMITATIONS TABLE – STATE BY STATE COMPARISON .......................... 6

III. THE STATE OF OHIO .................................................................................................................. 7
   A. FREQUENTLY CITED OHIO STATUTES .............................................................................. 7
      1. General Considerations in Insurance Claims Management ................................................. 7
      2. Clarification of Facts and Legal Duties ................................................................................. 8
      3. Uninsured Motorist Coverage ............................................................................................. 8
      4. Statutory Subrogation Rights ............................................................................................... 9
      5. Liability and Damages Considerations ............................................................................. 10
      6. Insurance Fraud .................................................................................................................. 14
   B. OHIO STATUTES OF LIMITATIONS .................................................................................. 17
   C. SIGNIFICANT OHIO COURT DECISIONS ....................................................................... 20
      1. Supreme Court Decisions .................................................................................................... 20
         a. Insurance Coverage Decisions ....................................................................................... 20
         b. Governmental Immunity Decision .................................................................................. 21
         c. Other Significant Decisions ............................................................................................ 21
      2. Appellate Court Decisions .................................................................................................. 23
         a. Insurance Coverage Decisions ....................................................................................... 23
         b. UM/UIM Decisions ........................................................................................................... 30
         c. Employment Decisions .................................................................................................... 31
         d. Premises Liability Decisions ............................................................................................ 32
         e. Governmental Immunity Decisions .................................................................................. 34
      3. Federal Court Decisions ....................................................................................................... 39
   D. SIGNIFICANT CASES PENDING BEFORE THE OHIO SUPREME COURT ............ 40

IV. THE COMMONWEALTH OF KENTUCKY .............................................................................. 42
   A. FREQUENTLY CITED KENTUCKY STATUTES ................................................................. 42
      1. Automobile Insurance ......................................................................................................... 42
      2. Negligence, Other Torts and Contribution ......................................................................... 43
      3. Insurance Fraud .................................................................................................................. 45
      4. Miscellaneous Statutes ....................................................................................................... 47
   B. KENTUCKY STATUTES OF LIMITATIONS ...................................................................... 50
   C. SIGNIFICANT KENTUCKY COURT DECISIONS .......................................................... 54
      1. Supreme Court Decisions .................................................................................................... 54
         a. Insurance Coverage Decision ....................................................................................... 54
         b. Other Significant Decisions ............................................................................................ 54
      2. Appellate Court Decisions .................................................................................................. 55
         a. Insurance Coverage Decisions ....................................................................................... 55
         b. UM/UIM Decisions ........................................................................................................... 57
         c. No-Fault/PIP Decision ....................................................................................................... 58
         d. Other Significant Decisions ............................................................................................ 59
      3. Federal Court Decisions ....................................................................................................... 65
   D. SIGNIFICANT CASES PENDING BEFORE THE KENTUCKY SUPREME COURT ... 66

V. THE STATE OF INDIANA ........................................................................................................... 68
   A. FREQUENTLY CITED INDIANA STATUTES ................................................................. 68
      1. Automobile Insurance ......................................................................................................... 68
      2. Negligence, Other Torts and Contribution ......................................................................... 68
      3. Subrogation .......................................................................................................................... 72
      4. Insurance Fraud .................................................................................................................. 73
      5. Miscellaneous Statutes ....................................................................................................... 75
   B. INDIANA STATUTES OF LIMITATIONS .......................................................................... 77
   C. SIGNIFICANT INDIANA COURT DECISIONS .............................................................. 78
      1. Supreme Court Decisions .................................................................................................... 78
         a. Insurance Coverage Decisions ....................................................................................... 78
         b. Other Significant Decisions ............................................................................................ 79
      2. Appellate Court Decisions .................................................................................................. 80
         a. Insurance Coverage Decisions ....................................................................................... 80
b. Premises Liability Decision ................................................................. 82
c. Other Significant Decisions ............................................................... 82

D. SIGNIFICANT CASES PENDING BEFORE THE INDIANA SUPREME COURT .......................................................... 84

VI. THE STATE OF MICHIGAN ........................................................................... 85

A. FREQUENTLY CITED MICHIGAN STATUTES ............................................. 85
1. General Considerations in Insurance Claims Management ...................... 85
2. Automobile Insurance ............................................................................. 88
3. General Liability Considerations ............................................................ 90
4. Miscellaneous Statutes ........................................................................... 92

B. MICHIGAN STATUTES OF LIMITATIONS .................................................. 94

C. SIGNIFICANT MICHIGAN COURT DECISIONS ......................................... 98
1. Supreme Court Decisions ........................................................................ 98
   a. Insurance Coverage Decisions ................................................................. 98
   b. No-fault/PIP Decision ............................................................................ 99
   c. Other Significant Decisions ................................................................... 99
2. Appellate Court Decisions ....................................................................... 100
   a. Insurance Coverage Decisions ................................................................. 100
   b. UM/UIM Decisions ................................................................................. 103
   c. Premises Liability Decisions ................................................................. 104
   d. Governmental Immunity Decision ......................................................... 106
   e. Other Significant Decisions ................................................................... 107
3. Federal Court Decisions .......................................................................... 108

D. SIGNIFICANT CASE PENDING BEFORE THE MICHIGAN SUPREME COURT .......................................................... 110

VII. THE STATE OF FLORIDA ............................................................................ 111

A. FREQUENTLY CITED FLORIDA STATUTES ............................................. 111
1. General Considerations in Insurance Claim Management ...................... 111
2. Insurance Fraud ....................................................................................... 114
3. Automobile Insurance ............................................................................. 115
4. Negligence, Other Torts and Contribution ............................................... 117
5. Miscellaneous Statutes ........................................................................... 117

B. FLORIDA STATUTES OF LIMITATIONS .................................................. 118

C. SIGNIFICANT FLORIDA COURT DECISIONS ......................................... 122
1. Supreme Court Decisions ........................................................................ 122
   a. Insurance Coverage Decision ................................................................. 122
   b. UM/UIM Decision .................................................................................. 122
2. Appellate Court Decisions ....................................................................... 123
   a. Insurance Coverage Decisions ................................................................. 123
   b. UM/UIM Decision .................................................................................. 125
   c. No-Fault (PIP) Decision ........................................................................ 125
   d. Premises Liability Decision .................
   e. Other Significant Decisions ................................................................... 126
3. Federal Decisions ...................................................................................... 128

D. SIGNIFICANT CASES PENDING BEFORE THE FLORIDA SUPREME COURT .......................................................... 132

VIII. THE STATE OF WEST VIRGINIA .............................................................. 133

A. FREQUENTLY CITED WEST VIRGINIA STATUTES .................................. 133
1. General Considerations in Insurance Claim Management ...................... 133
2. Insurance Fraud ....................................................................................... 134
3. Automobile Insurance ............................................................................. 135
4. Negligence, Other Torts and Contribution ............................................... 135
5. Miscellaneous Statutes ........................................................................... 135

B. WEST VIRGINIA STATUTES OF LIMITATIONS ....................................... 137

C. SIGNIFICANT WEST VIRGINIA COURT DECISIONS ................................ 139
1. Supreme Court of Appeals Decisions ...................................................... 139
   a. Insurance Coverage Decisions ................................................................. 139
   b. Other Significant Decisions ................................................................... 140
2. Federal Court Decisions .......................................................................... 142
I. OFFERS OF JUDGMENT: STATE-BY-STATE SUMMARY

Introduction

An offer of judgment can be a useful tool to settle a case, particularly at the outset of the litigation, before significant expenses have been incurred. The federal courts and all but five (5) states have adopted some version of an offer of judgment rule. Although there are many variations, the follow example illustrates generally how an offer of judgment works.

Consider a personal injury case where liability is clear, and the main issue is the plaintiff’s extent of damages. Suppose defendant makes an offer of judgment of Twenty-Five Thousand Dollars ($25,000.00), including costs accrued as of the time of the offer. The plaintiff has a limited time to accept the offer (the time limitation varying by jurisdiction). If the plaintiff rejects the offer of judgment, and the amount of the judgment the plaintiff ultimately obtains is less than the offer of judgment, then plaintiff must pay all costs incurred after the date on which the offer of judgment was made. Depending upon the jurisdiction, such costs may include attorney’s fees.

When defendant makes an offer of judgment at the early stages of the case, the plaintiff is forced to consider seriously the chances of obtaining a jury verdict greater than the offer of judgment. Even if the plaintiff does not accept the offer of judgment, it may prompt the plaintiff to make a counterproposal, which could result in an early settlement of the case.

This article is intended to provide a brief overview of the federal rule concerning offers of judgment, followed by a state-by-state summary. It should be noted there are significant variations among the jurisdictions which recognize offers of judgment.

Offers of Judgment Under the Federal Rule

Federal Rule of Civil Procedure 68 provides that a defending party to a claim may make an offer to the opposing party, with costs accrued. The offer must be made at least fourteen (14) days before the start of trial. Offers may also be made after liability is determined, by the party held liable, but such offers must be served at least fourteen (14) days before the date set for the hearing to determine the extent of liability. If an offer is accepted, the clerk then enters judgment. If an offer is unaccepted, it has two effects. First, the offer is not admissible except to determine costs. Second, if the judgment obtained by the plaintiff is less that the offer, then the plaintiff must pay the costs incurred after the offer was made.

Generally, attorney’s fees are not considered as costs under Federal Rule 68. However, where there is an underlying federal statute that defines attorney’s fees as part of costs, the Supreme Court interprets Federal Rule 68 to include attorney fees as costs. (Sherman & Fairman, “2010 Symposium: Codifying Mediation 2.0: Interplay Between Mediation and Offer of Judgment Rule Sanctions,” 26 Ohio St. J. on Disp. Resol. 327 (2011), citing City of Riverside v. Rivera, 477 U.S. 561, 580 (1986)). As a practical matter, therefore, where one of the plaintiff’s claims asserted in a federal case allows for an award of attorney fees under federal law, then attorney’s fees will be considered as costs under the federal offer of judgment rule.
State-by-State Summary

Most states have adopted a rule similar to the Federal Rule 68. Nineteen (19) states mirror the federal rule, except for variations on how many days before the start of trial the offer can be made. Five (5) states allow only the defending party to make an offer, and otherwise vary the federal rule in terms of determining the costs to be paid. Twenty (20) states allow either party to make the offer, and prescribe different methods of calculating the costs that must be paid. One state allows offers of judgment only in medical malpractice cases. Illinois, New Hampshire, Pennsylvania, Texas, and Virginia are the only five (5) states that have not adopted an offer of judgment rule or statute.

States That Mirror the Federal Rule

The following nineteen (19) states mirror the federal rule, except for variations on how many days before the start of trial the offer must be made:

- Alabama
- Arkansas (excludes attorney’s fees)
- Delaware
- Indiana
- Kansas
- Kentucky
- Maine
- Massachusetts
- Mississippi
- Missouri
- Montana
- Nebraska
- New York
- North Carolina
- Rhode Island
- Tennessee
- Vermont
- Washington
- West Virginia

States That Allow for Offers of Judgment from Either Party

Twenty (20) states mirror the federal rule, except for variations in time to make the offer, and by allowing either party to make the offer. These states also often provide for particular methods of determining the costs the other party must pay if an offer is rejected. These states, with the method of determining costs, are displayed in the below table.

<table>
<thead>
<tr>
<th>State</th>
<th>Offer Made by Defendant</th>
<th>Offer Made by Plaintiff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>If judgment entered is at least 5% less favorable to the offeree than the offer, the offeree shall pay all costs, including reasonable attorney’s fees.</td>
<td>If judgment entered is at least 5% less favorable to the offeree than the offer, the offeree shall pay all costs, including reasonable attorney’s fees.</td>
</tr>
<tr>
<td>State</td>
<td>Offeror May Choose to Exclude Attorney’s Fees, But Must Specifically State in the Offer. If Offeree Does Not Obtain a More Favorable Judgment, the Offeree Must Pay Double the Taxable Costs, Reasonable Expert Witness Fees, and Pre-Judgment Interest on Unliquidated Claims.</td>
<td>Offeror May Choose to Exclude Attorney’s Fees, But Must Specifically State in the Offer. If Offeree Does Not Obtain a More Favorable Judgment, the Offeree Must Pay Double the Taxable Costs, Reasonable Expert Witness Fees, and Prejudgment Interest on Unliquidated Claims.</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Arizona</td>
<td>If Offeror elects to exclude attorney’s fees, they must specifically state in the offer. If the offeree does not obtain a more favorable judgment, the offeree must pay double the taxable costs, reasonable expert witness fees, and pre-judgment interest on unliquidated claims. If the offeree does not obtain a more favorable judgment, the offeree must pay double the taxable costs, reasonable expert witness fees, and pre-judgment interest on unliquidated claims.</td>
<td>If the offeror elects to exclude attorney’s fees, they must specifically state in the offer. If the offeree does not obtain a more favorable judgment, the offeree must pay double the taxable costs, reasonable expert witness fees, and pre-judgment interest on unliquidated claims. If the offeree does not obtain a more favorable judgment, the offeree must pay double the taxable costs, reasonable expert witness fees, and pre-judgment interest on unliquidated claims.</td>
</tr>
<tr>
<td>California</td>
<td>If plaintiff fails to obtain more favorable judgment, plaintiff shall pay defendant’s costs, and such costs shall be deducted from any damages awarded in favor of plaintiff. The court may also, in its discretion, require plaintiff to pay reasonable costs of expert witness.</td>
<td>If defendant fails to obtain a more favorable judgment, the court may require defendant to pay reasonable costs of expert witness.</td>
</tr>
<tr>
<td>Colorado</td>
<td>If plaintiff does not recover in excess of amount offered, then defendant awarded actual costs, not including attorney’s fees, to be paid by plaintiff. If plaintiff prevails, the plaintiff’s judgment includes amount of plaintiff’s actual costs prior to the offer.</td>
<td>If plaintiff recovers in excess of amount offered, defendant shall pay actual costs, not including attorney’s fees, accruing after the offer.</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Plaintiff to pay defendant’s costs, including attorney’s fees.</td>
<td>Costs in excess of the offer are added to the judgment award, including attorney’s fees.</td>
</tr>
<tr>
<td>Florida</td>
<td>Defendant entitled to recover reasonable costs and attorney’s fees. If costs exceed judgment, the judgment shall be entered against plaintiff for the costs, less the amount of plaintiff’s award. Offer must have been made in good faith – if bad faith, then no attorney’s fees.</td>
<td>If plaintiff recovers at least 25% more than offer, plaintiff entitled to costs and attorney’s fees. Offer must have been made in good faith – if bad faith, then no attorney’s fees.</td>
</tr>
<tr>
<td>Georgia</td>
<td>Defendant entitled to attorney’s fees and costs, if the plaintiff’s judgment is less than 75% of offer. To recover attorney’s fees, offer must have been made in good faith.</td>
<td>If plaintiff recovers 125% more than offer, then plaintiff entitled to attorney’s fees and costs. To recover attorney’s fees, offer must have been made in good faith.</td>
</tr>
<tr>
<td>Hawaii</td>
<td>If judgment not more favorable than offer, offeree must pay costs incurred after making the offer.</td>
<td>If judgment not more favorable than offer, offeree must pay costs incurred after making the offer.</td>
</tr>
<tr>
<td>State</td>
<td>Louisiana</td>
<td>Nevada</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Offer</td>
<td>If judgment at least 25% less than defendant’s offer, the offeree must pay offeror’s costs, excluding attorney’s fees.</td>
<td>If judgment at least 25% greater than offer, the offeree must pay offeror’s costs, excluding attorney’s fees.</td>
</tr>
<tr>
<td>Defendant</td>
<td></td>
<td>If judgment obtained by plaintiff more favorable than offer, plaintiff must pay costs, excluding attorney’s fees.</td>
</tr>
<tr>
<td>Offeror</td>
<td></td>
<td>If offeree fails to obtain more favorable judgment than offer, the offeree cannot recover costs or attorney fees and shall pay the offeror’s post-offer costs.</td>
</tr>
<tr>
<td>Offeree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offeror</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>Either party can make an offer and a counteroffer. Costs paid by offeree if offer rejected are determined based on the average offer, which is the average of the offer and counteroffer. If the judgment is more favorable to the offeror than the average offer, the offeror must pay costs, including attorney fees. If the judgment is more favorable to the offeree than the average offer, the offeror must pay the same. However, an offeree who does not make a counteroffer may not recover costs unless the offer was made less than 42 days before trial.</td>
<td>Either party can make an offer and a counteroffer. Costs paid by offeree if offer rejected are determined based on the average offer, which is the average of the offer and counteroffer. If the judgment is more favorable to the offeror than the average offer, the offeror must pay costs, including attorney fees. If the judgment is more favorable to the offeree than the average offer, the offeror must pay the same. However, an offeree who does not make a counteroffer may not recover costs unless the offer was made less than 42 days before trial.</td>
</tr>
<tr>
<td>State</td>
<td>Offer Details</td>
<td>Plaintiff is the Offeror and the Recovery is Less Favorable to the Defendant, the Defendant Must Pay Costs.</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Either party can make an offer. Parties must offer either damages-only or total obligation, including attorney’s fees. If Defendant is the offeror and the defendant prevails, the plaintiff must pay the costs. If the defendant is the offeror and the plaintiff’s recovery is less favorable than the offer, the plaintiff must pay costs.</td>
<td>If the plaintiff is the offeror and the recovery is less favorable to the defendant, the defendant must pay costs.</td>
</tr>
<tr>
<td>Ohio</td>
<td>While either party can make an offer, it is not to be construed for the purposes of determining costs.</td>
<td>While either party can make an offer, it is not to be construed for the purposes of determining costs.</td>
</tr>
<tr>
<td>Oregon</td>
<td>If judgment less favorable than offer, then offeree must pay costs, excluding attorney’s fees.</td>
<td>If judgment less favorable than offer, then offeree must pay costs, excluding attorney’s fees.</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Any party may offer. If judgment at least as favorable as offer, offeror shall recover from the offeree costs and 8% reduction in award if offeror is defendant.</td>
<td>Any party may offer. If judgment at least as favorable as offer, offeror shall recover from the offeree costs and 8% reduction in award if offeror is defendant.</td>
</tr>
<tr>
<td>South Dakota</td>
<td>If judgment not more favorable than offer, offeree must pay costs.</td>
<td>If judgment not more favorable than offer, offeree must pay costs.</td>
</tr>
<tr>
<td>Utah</td>
<td>Either party may offer. Offeree’s payment based on adjusted award amount. Adjusted award means amount awarded by fact-finder, offeree’s costs, and offeree’s attorney’s fees. If the adjusted award is less favorable than the offer, the offeree shall pay the offeror’s costs.</td>
<td>Either party may offer. Offeree’s payment based on adjusted award amount. Adjusted award means amount awarded by fact-finder, offeree’s costs, and offeree’s attorney’s fees. If the adjusted award is less favorable than the offer, the offeree shall pay the offeror’s costs.</td>
</tr>
</tbody>
</table>

**States That Allow for Offers from the Defending Party**

The following five (5) states allow for offers of judgment from the defending party, but otherwise modify the federal rule.

**Idaho:** Idaho’s rule allows only for defendants to make offers. Costs to be paid by the offeree are determined on the basis of the adjusted award. The adjusted award is the verdict, plus the offeree’s costs before the offer, plus attorney’s fees before the offer. If the adjusted award is less than the offer, the offeror/defendant must pay those costs incurred after the offer, before the offer, but not attorney’s fees after the offer. If the adjusted award is more than the offer, the offeror/defendant must pay costs both before and after the offer.
Iowa: Defendant may confess judgment. If plaintiff brings action anyway and does not recover more than defendant’s offer, then plaintiff pays costs. Defendant can also make a conditional offer for an agreed judgment award, contingent on defendant’s failure.

Oklahoma: Only defendant may make an offer. Offers shall be deemed to include attorney’s fees, unless expressly provided otherwise. If plaintiff rejects and recovers less than the offer, the defendant is entitled to costs and attorney fees. If judgment is greater than one or more counteroffers of judgment, the plaintiff is entitled to costs and attorney fees.

Wisconsin: Only the defendant may offer. If recovery is greater than or equal to the offer, the recovering party is entitled to interest at an annual rate equal to 1% plus the prime rate.

Wyoming: Defendant may confess judgment before trial. If plaintiff brings action anyway and does not recover more than defendant’s offer, then plaintiff pays costs, including interest.

States That Limit Offers of Judgment to Narrow Circumstances

One state, Maryland, limits offers of judgment to medical malpractice cases. Either party can make an offer. If judgment is less favorable than offer, the offeree shall pay the costs of the offeror incurred after making the offer.

States That Include Attorney’s Fees in Costs Offeree Must Pay

The following seven (7) states specifically include attorney’s fees in the costs an offeree must pay:

- Alaska
- Arizona (unless offer specifically excludes attorney’s fees)
- Connecticut
- Florida (if offer made in good faith)
- Georgia (if offer made in good faith)
- Minnesota (if offer is a total obligations offer)
- Oklahoma (unless offer specifically excludes attorney’s fees)

Conclusion

An offer of judgment is a tool often overlooked in considering alternatives to resolve a case. It may be particularly useful in a clear liability case to extend an early offer of judgment, as this will force opposing counsel to consult with the client, and explain the repercussions if the case proceeds to trial and the verdict is less than the offer of judgment. This may result in leading to further negotiations and perhaps a resolution of the case in its early stages before significant litigation expenses are incurred by all parties.
## II. STATUTES OF LIMITATIONS TABLE – STATE BY STATE COMPARISON

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Ohio</th>
<th>Kentucky</th>
<th>Indiana</th>
<th>Michigan</th>
<th>Florida</th>
<th>West Virginia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault &amp; Battery</td>
<td>1 year R.C. §2305.111</td>
<td>1 year K.R.S. §413.140</td>
<td>2 years I.C. §34-11-2-4 (1)</td>
<td>2 years M.C.L.A. §600.5805 (2)- (4)</td>
<td>4 years Fla. Stat. §95.11(3)(o)</td>
<td>2 years W. Va. Code §55-2-12(b)</td>
</tr>
<tr>
<td>Bodily Injury Due to Negligence</td>
<td>2 years R.C. §2305.10</td>
<td>Auto Acc. – 2 yrs. K.R.S. §304.39-230</td>
<td>2 years I.C. §34-11-2-4 (1)</td>
<td>3 years M.C.L.A. §600.5805(10)</td>
<td>4 years Fla. Stat. §95.11(3)(a)</td>
<td>2 years W.Va. Code §55-2-12(b)</td>
</tr>
<tr>
<td>Personal Property Damage Due to Negligence</td>
<td>2 years R.C. §2305.10</td>
<td>2 years K.R.S. §413.125</td>
<td>2 years I.C. §34-11-2-4 (2)</td>
<td>3 years M.C.L.A. §600.5805(10)</td>
<td>4 years Fla. Stat. §95.11(3)(a)</td>
<td>2 years W.Va. Code §55-2-12(a)</td>
</tr>
<tr>
<td>Wrongful Death</td>
<td>2 years R.C. §2125.02</td>
<td>1 year (from appt.) K.R.S. §413.180</td>
<td>2 years I.C. §34-23-1-1</td>
<td>3 years M.C.L.A. §600.5805(10)</td>
<td>2 years Fla. Stat. §95.11(4)(d)</td>
<td>2 years W.Va. Code §55-7-6</td>
</tr>
<tr>
<td>Libel, Slander, Defamation</td>
<td>1 year R.C. §2305.11</td>
<td>1 year K.R.S. §413.140</td>
<td>2 years I.C. §34-11-2-4</td>
<td>1 year M.C.L.A. §600.5805(9)</td>
<td>2 years Fla. Stat. §95.11(4)(g)</td>
<td>1 year W.Va. Code §55-2-12(c)</td>
</tr>
<tr>
<td>Bad Faith</td>
<td>4 years R.C. §2305.09(D)</td>
<td>5 years K.R.S. §413.120</td>
<td>2 years I.C. §34-11-2-4(2)</td>
<td>N/A</td>
<td>5 years Fla. Stat. §95.11(2)(b) (breach of contract action)</td>
<td>1 year W.Va. Code §55-2-12(c)</td>
</tr>
<tr>
<td>Contract in Writing</td>
<td>8 years R.C. §2305.06</td>
<td>15 years K.R.S. §413.090(2)</td>
<td>10 years I.C. §34-11-2-11</td>
<td>6 years M.C.L.A. §600.5807(8)</td>
<td>5 years Fla. Stat. §95.11(2)(b)</td>
<td>10 years W.Va. Code §55-2-6</td>
</tr>
<tr>
<td>Contract not in Writing</td>
<td>6 years R.C. §2305.07</td>
<td>5 years K.R.S. §413.120(1)</td>
<td>6 years I.C. §34-11-2-7(1)</td>
<td>6 years M.C.L.A. §600.5807(8)</td>
<td>4 years Fla. Stat. §95.11(3)(k)</td>
<td>5 years W.Va. Code §55-2-6</td>
</tr>
<tr>
<td>Fraud</td>
<td>4 years R.C. §2305.01(C)</td>
<td>5 years K.R.S. §413.120(12)</td>
<td>6 years I.C. §34-11-2-7(4)</td>
<td>6 years M.C.L.A. §600.5813</td>
<td>4 years Fla. Stat. §95.11(3)(j)</td>
<td>2 years W.Va. Code §55-2-12 (common law fraud)</td>
</tr>
</tbody>
</table>
III. **THE STATE OF OHIO**

A. **FREQUENTLY CITED OHIO STATUTES**

1. **General Considerations in Insurance Claims Management**

   **Ohio Administrative Code § 3901-1-54**
   
   **Unfair Claims Practices**
   
   This provision is not a statute but is part of the state regulations governing insurers. It governs unfair settlement practices in the handling of property and casualty claims. Numerous minimum standards of conduct for claims representatives are set forth. It was substantially modified in November 2004.

   Although the code expressly provides violations of the code may result in disciplinary action being taken by the Department of Insurance, violations do not lead to civil liability, even on first-party claims.

   **R.C. § 2111.18**
   
   **Settlement of Minor’s Claims**
   
   All settlements of personal injury claims of minors must be approved by the probate court of the county where the minor resides.

   Amended by 2009 Ohio SB 106 to change the amount of net settlement from $10,000.00 or less to $25,000.00 or less after payment of fees and expenses. Additional language added includes: “In the settlement, if the ward is a minor, the parent or parents of the minor may waive all claim for damages on account of loss of service of the minor, and that claim may be included in the settlement.”

   **R.C. § 3737.16**
   
   **Release of, or Request For, Information Relating to Fire Loss by Insurance Company**
   
   Civil authorities investigating property fire losses (including the fire marshal, a fire department chief, local law enforcement, or the county prosecutor) may request an insurance company investigating a property fire loss to release any information in its possession concerning the loss.

   **R.C. § 4505.11**
   
   **Salvage Titles**
   
   If it is economically impractical to repair a vehicle and the insurer has paid the owner an agreed sum for the purchase of the vehicle, the insurer shall obtain the title and within thirty (30) days obtain a salvage title.

   If the owner retains possession of the vehicle, the insurer cannot pay the owner to settle the claim until the owner first obtains a salvage title.
R.C. § 4509.51
Automobile Minimum Liability Limits
The statute requires minimum automobile liability coverage limits (per accident) of: (1) $25,000.00 for bodily injury or death of any one person in any accident; (2) $50,000.00 for bodily injury to or death of two or more persons in any one accident; and (3) $25,000.00 for injury to property of others in any one accident.

R.C. § 4509.53(D)
Motor Vehicle Insurance Policy Applications
The written application of insurance is part of a motor vehicle liability policy.

2. Clarification of Facts and Legal Duties

R.C. § 2317.48
Action for Discovery
When information and facts surrounding a case are difficult to obtain, a person claiming to have a cause of action, or a person against whom a cause of action has been filed, may bring an action for discovery. A discovery action allows such party to explore the strengths of the complaint or defense without subjecting the party to the potential penalties associated with frivolous lawsuits.

R.C. §§ 2721.01 et. seq.
Declaratory Judgment Actions
This chapter allows parties to file suit to have the court determine the validity of a contract and/or the rights of the parties under the contract. This is the most effective tool for resolving disputes on the availability or amount of insurance coverage available.

Effective September 24, 1999, a plaintiff who is not an insured under a policy cannot bring a declaratory judgment action against a third party’s insurer to determine if coverage is available for a claim until or unless a final judgment has been placed of record awarding the plaintiff damages against the insured.

R.C. § 4123.01(A)(1)(c)
“Employee” Under Construction Contract
The statute sets out specific factors to determine whether a person is an “employee” under a construction contract.

3. Uninsured Motorist Coverage

R.C. § 3937.18
UM/UIM Coverage
(A) Effective October 31, 2001, an insurer no longer has a duty to offer UM/UIM coverage to its insured with the sale of a policy. As a result, there will no longer be any requirement that a rejection or reduction in coverage be in writing.

(A) UIM coverage is not excess coverage.

(G) Insurers may preclude both inter-family and intra-family stacking in their policies.
(H) On wrongful death claims, any claim for a single death is subject to the per person limit on coverage.

(H) An insured has a three-year statute of limitations to assert a UM/UIM claim, assuming they did not destroy the insurer’s right of subrogation.

(K) A vehicle available for the regular use of the insured, a family member, or a fellow household member can be deemed an uninsured vehicle.

(L) These requirements only apply to policies meeting the financial responsibility requirements or to umbrella policies.

**R.C. § 3937.44**  
**Per Person Limits**

For both liability and UM/UIM coverages, only the per person limit is available for recovery for each person suffering a bodily injury or for each decedent.

4. **Statutory Subrogation Rights**

**R.C. § 2744.05**  
**Immunity of Political Subdivisions to Subrogation Claims**

Political subdivisions are immune to any subrogation claim brought by an insurer.

**R.C. § 3937.18(E)**  
**UM/UIM Claims**

In the event of payment to an insured for an uninsured/underinsured motorist claim, the insurer making such payment is entitled to the proceeds of any settlement or judgment resulting from the exercise of the insured’s rights against a legally liable party. This right is limited by relevant insolvency proceedings.

**R.C. § 3937.21**  
**Subrogation**

If an insurance company pays to, or on behalf of, its insured any amount later determined to be due from another insurer, it shall be subrogated to all rights of the insured against such insurer.

**R.C. § 4123.93**  
**Workers’ Compensation Subrogation Rights**

This statute became effective April 9, 2003, and therefore applies only to injuries occurring on or after that date. It restores subrogation rights of the Ohio Bureau of Workers’ Compensation and self-insured employers. For claims where the injury occurred prior to April 9, 2003, there is no right of subrogation.

Employees now must notify the lienholder if there is a third-party who is responsible for their injuries so that there is a reasonable opportunity to assert their subrogation rights. Responsible parties include UM/UIM insurers.

If an employee is not made whole, then the statute prescribes a formula for pro-rata distribution of any recovery between the employee and lienholder.
If there is the potential for future payments by the lienholder, a portion of the recovery is to be put in an interest-bearing trust account to protect any future lien.

5. Liability and Damages Considerations

R.C. § 1533.181
Immunity – Recreational User Claims

The statute provides where a premises owner may be immune from claims by a recreational user of the premises.

R.C. §§ 2125.01 et. seq.
Wrongful Death Actions

A wrongful death action can only be brought by the executor or administrator of the decedent’s estate.

The decedent’s surviving spouse, parents, and children are rebuttably presumed to have been damaged by the death.

All other family members must prove their entitlement to damages.

R.C. § 2305.402
Pending Changes to Trespass Liability Statute

Pending 2012 Ohio Senate Bill 202 would specify the responsibility of a possessor of real property to a trespasser and the circumstances in which the possessor may be liable in a tort action for the death or injury of a trespasser. The amendment seeks to clarify that it is the intent of the General Assembly to declare that the American Law Institute's finalized "Restatement Third of Torts: Liability for Physical and Emotional Harm" does not constitute the public policy of the state of Ohio. If passed, Senate Bill 202 would codify the longstanding common law rule that a land possessor owes no duty of care to a trespasser except to refrain from willful, wanton, or reckless conduct that is likely to injure the trespasser. This change would also keep in place Ohio’s current exceptions to this rule where a land possessor owes a trespasser a duty of reasonable care.

R.C. § 2307.22
Allocation of Damages

This statute only applies to claims where the injury occurred on or after April 8, 2003. If there are multiple defendants at fault, any defendant who is more than fifty percent at fault is subject to joint and several liability for the plaintiff’s economic damages. All other at-fault defendants are liable only to the proportionate extent of their liability. All at-fault defendants are only proportionally liable for non-economic damages.

If there are multiple defendants at fault, and no one defendant is more than fifty percent at fault, then the at-fault defendants are liable only to the proportionate extent of their liability for both economic and non-economic damages. The only exception exists for intentional tortfeasors, who are still subject to joint and several liability for economic damages.
R.C. § 2307.25
Right of Contribution

This statute only applies to claims where the injury occurred on or after April 8, 2003. A right of contribution will exist only if two or more tortfeasors are subject to joint and several liability.

R.C. § 2307.28
Set-offs for Damages

This statute only applies to claims where the injury occurred on or after April 8, 2003. A non-settling defendant is entitled to a set-off from any award of damages from what a plaintiff has already recovered from any settling party. This right exists even if the settling party is not found to be liable. This overrules *Fildelholtz v. Peller*, (1998), 81 Ohio St. 3d 197, which required a finding the settling party was liable before a set-off could be imposed.

R.C. § 2307.32
Enforcement of Contribution

This statute only applies to claims where the injury occurred prior to April 8, 2003. If the injury occurred on or after that date, R.C. § 2307.25 is applicable instead.

A party has one year from the date of judgment against it to seek contribution from joint tortfeasors.

If the party settles a claim without a judgment, that party has one year from the date of settlement in which to seek contribution.

A party who enters into a good faith settlement with a plaintiff or claimant for only a portion of the plaintiff’s damages is immune to claims for contribution from other tortfeasors. The release of claims bars any contribution claims of joint tortfeasors made either before or after the date of settlement.

R.C. § 2307.711
Comparative Fault in Product Liability Actions

Assumption of risk is a defense in product liability claims. Depending upon the nature of the assumption of risk, it can be an absolute bar to a plaintiff’s recovery, without any comparative fault analysis, or serves as a proportionate basis for reducing damages and liability. This statute took effect in April 2005.

R.C. § 2315.18
Caps on Compensatory Damages

There are no caps on economic damages. There are no caps on non-economic damages for “catastrophic” injuries, which are defined as “permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or permanent physical functional injury that permanently prevents the injured person from being able to independently care for and perform life-sustaining activities.” With respect to “non-catastrophic” injuries, non-economic damages are capped at the greater of $250,000.00 or three (3) times the amount of economic damages, with an absolute maximum of $350,000.00 per plaintiff or $500,000.00 per occurrence. Thus, if an individual plaintiff incurs more than $83,333.00 in economic loss damages, the cap for non-economic damages increases from $250,000.00 to $350,000.00.
R.C. § 2315.19  
**Comparative Fault**

A plaintiff’s recovery is reduced in proportion to their percentage of comparative fault. If a plaintiff is 51% or more at fault, they are barred from recovery.

For injuries occurring prior to April 8, 2003, there is joint and several liability among joint tortfeasors for economic damages. For non-economic damages there is only several liability among joint tortfeasors. If the injury occurred on or after April 8, 2003, R.C. § 2307.22 is applicable instead.

R.C. § 2315.20  
**Collateral Benefits**

A defendant in a tort action may introduce evidence of certain collateral benefits for the plaintiff, with stated exceptions. One such exception is if the source of collateral benefits has a federal, contractual or statutory right of subrogation.

R.C. § 2315.21  
**Punitive or Exemplary Damages**

Effective April, 2005, a defendant now has an absolute right to bifurcate a trial on a punitive damage claim.

Punitive damages are capped at one to two times the amount of any compensatory damage award. In the case of a small employer or private individual, punitive damages are capped at two times the amount of damages or ten percent of their net worth.

R.C. § 2317.02  
**Waiver of Physician-Patient Privilege**

By filing a tort action, a plaintiff waives any physician-patient privilege and the defendant is entitled to obtain the entirety of the plaintiff’s medical records.

R.C. § 2745.01  
**Workplace Substantial Certainty Torts**

This statute took effect April 7, 2005. It reflects the latest legislative effort to codify workplace substantial certainty torts. An employee making such a claim must now either prove the employer intended to injure them or that the employer acted with the belief that injury was substantially certain to occur. Substantial certainty is considered a deliberate intent to cause injury, disease, or death. The statute goes on to provide that the deliberate removal of a safety guard or any misrepresentation of a toxic or hazardous substance creates a rebuttable presumption of an intent to injure.

R.C. § 3109.09 and § 3109.10  
**Parental Liability**

Liability of the parents is limited to $10,000.00 where their child willfully damages property or commits a theft offense (R.C. § 3109.09) and where their child has assaulted someone (R.C. § 3109.10).
R.C. § 3929.06
Insurance Money Applied to Judgment

Once a final judgment is entered in favor of a plaintiff against a person insured against such liability, after thirty (30) days the judgment creditor may file a supplemental complaint directly against the insurer to pay the amount of the unpaid judgment against the insured.

R.C. § 3929.25
Extent of Liability Under Policy (Valued Policy Statute)

The valued policy statute applies to any structure insured against loss by fire or lightning. In case of a total loss the insurer shall pay the amount of the policy; however, if the policy requires actual repair or replacement of the structure, then the amount paid shall be as prescribed by the policy.

R.C. § 3929.86
Fire Loss Claim – Payment of Property Taxes

Where fire damage to a structure exceeds $5,000.00, the statute sets forth procedures for payment of delinquent property taxes from the insurance proceeds.

R.C. § 3937.182
No Insurance for Punitive Damages

Motor vehicle policies cannot insure against punitive damages.

R.C. § 4123.741
Fellow Employee Tort Immunity

An employee may not bring suit against an employer or fellow employee for injuries sustained as a result of the negligence of the employer or fellow employee.

The injury must have occurred within the scope and course of employment and be compensable under Workers’ Compensation laws.

The statutory immunity does not apply to intentional torts.

R.C. § 4319.18
Liquor Liability Claims

This statute limits the scope of claims against a tavern due to actions of an intoxicated person resulting in injury to a third party.

R.C. § 4513.263
Seatbelt Defense

This statute became effective April 2005. A defendant may now interject evidence the plaintiff failed to wear a seatbelt. This evidence is not admissible for the purposes of establishing liability but can be utilized to establish a plaintiff’s injuries would not have occurred or not have been as severe, had a seatbelt been worn.
6. Insurance Fraud

**R.C. § 2913.47(B)(1)**
Presenting Fraudulent Claims

A person commits insurance fraud if, while acting with purpose to defraud or knowing the person is facilitating a fraud, the person presents or causes to be presented any written or oral statement that is part or in support of an application for insurance or a claim for a benefit under a policy of insurance, knowing the statement, in whole or in part, is false or deceptive.

**R.C. § 2913.47(B)(2)**
Fraud in the Application or Claim for Insurance

It is illegal to assist, aid, abet, solicit, procure, or conspire with another to prepare or make any written or oral statement intended to be presented to an insurer as part or in support of an application for insurance or a claim for a benefit under a policy of insurance, knowing the statement, in whole or in part, is false or deceptive.

**R.C. § 2913.47(C)**
Penalties

First Degree Misdemeanor—Fraudulent claims in an amount less than $500.00.

Fifth Degree Felony—Fraudulent claims between $500.00 and $4,999.99.

Fourth Degree Felony—Fraudulent claims between $5,000.00 and $99,999.99.

Third Degree Felony—Fraudulent claims of $100,000.00 or more.

**R.C. § 3904.01(T) and § 3904.03**
Pretext Interviews

A “pretext interview,” as defined in R.C. § 3904.01(T), is an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following:

1. Pretends to be someone else;
2. Pretends to represent another entity;
3. Misrepresents the true purpose of the interview; and/or
4. Refuses to identify himself/herself.

An insurer is generally prohibited from using pretext interviews to obtain information in connection with an insurance transaction; however, a pretext interview may be undertaken to obtain information for the purpose of investigating suspected criminal activity, fraud, material misrepresentation, or a material non-disclosure in connection with an insurance claim.
**R.C. § 3904.13**
**Disclosure of Personal or Privileged Information by an Insurance Carrier**

An insurer is prohibited from disclosing any personal or privileged information about an individual collected or received in connection with an insurance transaction, unless the disclosure is necessary for detecting or preventing criminal activity, fraud, material misrepresentation, or a material non-disclosure in connection with an insurance action.

Disclosed information must be limited to that which is reasonably necessary to detect or prevent criminal activity, fraud, material misrepresentation, or a material non-disclosure in connection with insurance transactions.

When the above conditions are met, disclosure may be made to law enforcement or other governmental agencies to protect the interest of the insurer in preventing and/or prosecuting fraudulent claims or if the insurer reasonably believes illegal activities have already been conducted by the individual.

**R.C. § 3911.06**
**False Answer in Application for Insurance**

An insurer is prohibited from denying recovery under a policy of insurance on the basis the applicant gave false answers in his application, unless it is proved the answer was willfully false, fraudulently made, material, and induced the company to issue the policy.

The agent or insurance company must have no prior knowledge of the application’s falsity or fraudulent nature prior to issuing the policy of insurance.

**R.C. § 3929.87**
**Time for Determination in Arson Investigation**

The Fire Marshall has ninety (90) days after a fire loss in excess of $5,000.00 to determine whether the loss was caused by arson.

**R.C. § 3937.42 and § 3937.99**
**Exchange of Information With Law Enforcement and Prosecuting Agencies**

An insurer has a legal obligation to notify law enforcement authorities when it has reason to suspect its insured has submitted a fraudulent motor vehicle claim.

Failure to notify the proper authorities constitutes a fourth degree misdemeanor.

**R.C. § 3999.21**
**Insurance Fraud Warnings**

All application and claim forms issued by an insurer must contain the following warning: *Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

Failure to include the warning is not a valid defense for insurance fraud.
**R.C. § 3999.31**
*Immunity for Providing or Receiving Information Relating to Suspected Fraudulent Insurance Acts*

No person is subject to liability for libel or slander by furnishing information to the Superintendent of Insurance relating to suspected fraudulent insurance acts. This immunity extends to any such information provided to any law enforcement official and any other person involved in the detection or prevention of fraudulent insurance acts.

**R.C. § 3999.41**
*Anti-Fraud Programs*

Every insurer is now required to adopt a written anti-fraud program. This program must include procedures for detecting insurance fraud.

Additionally, this program is to identify the person(s) responsible for the anti-fraud program.

Those not yet engaged in the business of insurance must submit a written plan within ninety (90) days after beginning to engage in the business of selling insurance.

**R.C. § 3999.42**
*Notice to Department of Insurance of Suspected Fraud*

Requires an insurer to notify the Ohio Department of Insurance whenever it suspects insurance fraud (as established in the Theft Fraud Law under R.C. § 3917.47) involving a claim of $1,000.00 or more.
## B. Ohio Statutes of Limitations

<table>
<thead>
<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault and Battery R.C. § 2305.111</td>
<td>One year from the date of assault or battery. If the identity of the person committing the assault or battery is unknown, the statute of limitations begins on the date plaintiff either learns the identity of the person or should have learned the identity of the person, whichever comes first.</td>
</tr>
<tr>
<td>Medical Malpractice R.C. § 2305.113</td>
<td>One year from the date of the malpractice incident. If the act of medical malpractice is not discoverable within one year, the plaintiff has one year from the date plaintiff knew or should have known of the malpractice, not to exceed four years from the date of malpractice.</td>
</tr>
<tr>
<td>Libel, Slander, Defamation R.C. § 2305.11</td>
<td>One year from the publication of the defamatory act.</td>
</tr>
<tr>
<td>Bodily Injury Due to Negligence R.C. § 2305.10</td>
<td>Two years from the date of incident.</td>
</tr>
<tr>
<td>Wrongful Death R.C. § 2125.02</td>
<td>Two years from the date of death.</td>
</tr>
<tr>
<td>Personal Property Damage Due to Negligence R.C. § 2305.10</td>
<td>Two years from the date of incident.</td>
</tr>
<tr>
<td>Product Liability Claims R.C. § 2305.10</td>
<td>Two years from the date of injury.</td>
</tr>
<tr>
<td>Claim Type/Section</td>
<td>Statute Period</td>
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<tr>
<td>UM/UIM Claims</td>
<td>Three years from the date of the accident. If the wrongdoer’s insurer becomes insolvent, then the plaintiff has one year from the date of insolvency to make the UM/UIM claim, even if it is more than three years after the accident.</td>
</tr>
<tr>
<td>R.C. § 3937.18</td>
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</tbody>
</table>

<table>
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<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
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<tbody>
<tr>
<td>Intentional Infliction of Emotional Distress</td>
<td>Four years from the date of incident.</td>
</tr>
<tr>
<td>R.C. § 2305.09</td>
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</table>

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<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Damage to Real Estate</td>
<td>Four years from the date the damage occurred.</td>
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<tr>
<td>R.C. § 2305.09</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Type/Section</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Fraud</td>
<td>Four years from the alleged act of fraud.</td>
</tr>
<tr>
<td>R.C. § 2305.09</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Breach of Covenant to Provide Adequate Insurance</td>
<td>Four years from the date inadequate insurance is discovered.</td>
</tr>
<tr>
<td>R.C. § 2305.09</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
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<th>Statute Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tort of Bad Faith</td>
<td>Four years from the alleged act of bad faith.</td>
</tr>
<tr>
<td>R.C. § 2305.09</td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Torts, Rights not Otherwise Enumerated</td>
<td>Four years after the cause thereof accrued.</td>
</tr>
<tr>
<td>R.C. § 2305.09</td>
<td></td>
</tr>
<tr>
<td>Claim Type/Section</td>
<td>Statute Period</td>
</tr>
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<td>-----------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Appeals</td>
<td>Unless otherwise provided by law, 30 days after the entry of the judgment or appealable order, whichever comes last. In a civil case, 30 days after service of notice of judgment and its entry.</td>
</tr>
<tr>
<td>Statutorily Created Actions</td>
<td>A liability created by statute, other than forfeiture or penalty, must be brought within six years of the date the claim arose.</td>
</tr>
<tr>
<td>Breach of Contracts Not in Writing</td>
<td>Six years from the date plaintiff’s claim first arose.</td>
</tr>
<tr>
<td>Breach of Contracts in Writing</td>
<td>Amended by 2012 Ohio Senate Bill 224 to reduce the statute of limitations period for actions based upon a breach of a written contract to eight (8) years. The new law shortens the period within which a lawsuit may be brought for breach of contract actions accruing both before and after the effective date of September 28, 2012. For claims that accrued prior to September 28, 2012, the limitations period is the earlier of: eight years from September 28, 2012; or the expiration of the limitations period in effect prior to the enacted of 2012 SB 224, which is 15 years from the date of the breach.</td>
</tr>
<tr>
<td>Minor’s Claims - Claims of Incompetent Persons</td>
<td>The limitation period for any minor’s claim does not begin until the minor reaches age 18. If a plaintiff is incompetent when injured, the limitation period does not begin until plaintiff is found competent.</td>
</tr>
</tbody>
</table>
C. Significant Ohio Court Decisions

1. Supreme Court Decisions
   a. Insurance Coverage Decisions


In Determining Whether an Insurance Policy Provision is Ambiguous, Court Must Consider the Overall Context in Which it is Used

Defendant filed a third party complaint against his insurance company in the wrongful death action as an insured under a commercial general liability (CGL) policy issued by the third party. The insurance company claimed the CGL policy excluded coverage in a wrongful death action. The trial court focused on a provision in the policy providing that ‘mobile equipment’ is not included within the definition of ‘auto’ and, therefore, was not excluded from coverage due to the ambiguity of the policy. The court of appeals agreed. The Supreme Court held that when interpreting a provision in the insurance policy, courts must look at the provision within the overall context of the policy when considering whether a provision is ambiguous. Because the CGL policy clearly provided that trailers were excluded from coverage, the Court reversed the decision of the court of appeals.


The Most Important Factor When Determining Domicile is “Where” the Person Intends to Remain

Plaintiff, an Ohio resident, was driving his own vehicle and struck a bicyclist who died. The decedent’s estate filed a wrongful death action and settled with the plaintiff’s insurer. Plaintiff then filed a declaratory judgment action against his parents’ personal umbrella insurer seeking indemnification coverage for the wrongful death action, arguing he was a “resident relative.” The parents are domiciled in Florida, but have an interest in the Ohio house where plaintiff resided. The trial court concluded there was no coverage because plaintiff was not a resident relative, but the court of appeals reversed, and the insurer appealed. The Supreme Court determined since plaintiff did not have the same “legal residence of domicile” as either of his parents, he was not an insured “resident relative” under the umbrella policy at issue.
b. Governmental Immunity Decision


The Employment Discrimination Provisions in R.C. 4112.01(A)(2) and 4112.02(A) do Not Expressly Impose Civil Liability on Individual Employees, but Instead Impose Vicarious Liability on the Political Subdivision Itself

Plaintiff filed an action against the defendant and her supervisor for a variety of claims including, age and sex-based discrimination. Defendant moved for summary judgment, arguing that they were entitled to immunity. The trial court granted defendant’s motion for summary judgment on most of plaintiff’s claims, but denied the motion as it related to defendant’s claim of sex discrimination under R.C. 4112.02(A) and Title VII. The appellate court agreed. However, the Supreme Court reversed, holding R.C. 4112.02(A)(2) and 4112.01(A) do not expressly impose civil liability on political subdivision employees as to trigger the immunity exception. Specifically, the employment-discrimination provisions in R.C. 4112.01(A)(2) and 4112.02(A) do not expressly impose civil liability on such employees, but instead impose vicarious liability on the political subdivision itself.

c. Other Significant Decisions

*Fraley v. Estate of Oeding*, 138 Ohio St.3d 250, 2014-Ohio-452

Nonresident is Not Subject To Personal Jurisdiction Based Solely on Insurer’s Conduct

After a motor vehicle accident in Indiana, plaintiff filed a complaint in Ohio alleging he suffered intangible economic loss in Ohio due to the defendant insurer’s five month investigative hold on the plaintiff’s truck. The Court held that Ohio courts do not have personal jurisdiction over nonresidents based solely on the conduct of the nonresident’s insurance company. The defendants did not have any contact with Ohio, and fundamental fairness precludes Ohio from subjecting nonresidents to the burdens of litigation simply because their insurance company engages in business in Ohio.

*Pixley v. Pro-Pak Industries, Inc.*, Slip Opinion No. 2014-Ohio-5460

In an Employer Intentional Tort Claim, Plaintiff Must Prove the Defendant Deliberately Removed the Safety Guard

Plaintiff, a maintenance worker for the defendant, his employer, sued for injuries after being struck by a transfer car. The trial court granted summary judgment for defendant and the appellate court reversed. The Supreme Court reversed the appellate court, holding the evidence failed to demonstrate the employer disabled the safety guard from the transfer which injured the employee.
Voluntary Abandonment of the Work Force Negated Temporary-Total-Disability Compensation

Plaintiff injured her back in a workplace accident. Following the accident, plaintiff’s employer switched her to light duty work in order to accommodate her workplace injury. Shortly after beginning light duty work, plaintiff voluntarily left her job saying she had to visit her doctor. Plaintiff showed no evidence she ever visited her doctor and after a few weeks her employer discharged her for voluntary abandonment. After her discharge, plaintiff attempted to file for temporary-total-disability compensation, but the claim was rejected by the Industrial Commission on the basis that job abandonment barred compensation. The Court agreed with the appellate court, holding plaintiff voluntarily separated from her employment and as a result was not entitled to temporary-total-disability compensation.

Jury Must be Instructed to Find That Agent Acted Within Scope of Agency Before Vicarious Liability Can be Imposed

Plaintiff filed suit against defendant and the defendant’s employer for fraud in the inducement in the sale of properties and other claims. The trial court returned a jury verdict in favor of the plaintiff against both employer and the defendant. Defendant’s employer appealed the decision on the basis that the jury instruction on vicarious liability was incorrect. The court of appeals ruled there was no fault with the jury instruction and that the defendant was acting within her scope of employment. The Supreme Court reversed, holding a jury first has to make a factual determination that the agent was acting within the scope of her agency when she committed the torts at issue, before submitting the vicarious liability issue to the jury.

The Doctrine of Dual Intent is Not Applicable When Determining Eligibility for Workers Compensation Benefits

Plaintiff was employed by the defendant to provide in-home health care services. On her way to see a client, plaintiff intended to drive her daughter, son and two family friends to the mall, but was involved in a car accident. Plaintiff filed for workers compensation benefits for a neck sprain. BWC allowed the claim, and the employer ultimately appealed to the common pleas court. The employer’s motion for summary judgment to deny the claim was granted. The appellate court reversed, finding that even though plaintiff had intended to drop her passengers off at the mall, she had had the dual intent to travel to her patient’s home, and that when she was injured, she had not yet diverted from that path. The Supreme Court reversed, holding that the doctrine of dual intent, or dual purpose, is not recognized in Ohio for purposes of determining eligibility for workers’ compensation benefits.
2. Appellate Court Decisions
   
a. Insurance Coverage Decisions


*Coverages Exists as a Matter of Law When Insurer Files SR-22 Certificate of Insurance, but Does Not File a SR-26 Notice of Cancellation With BMV*

Defendant insurer denied coverage and refused to defend a recent applicant for insurance following a car accident that injured plaintiff and killed plaintiff’s son. The insurer sent a letter to the applicant a month before the accident stating the policy would be cancelled in two weeks on the basis the underwriting department determined the applicant was an ineligible risk. The applicant’s license was suspended on the basis of having 12 points, but at the time of his application, he was provided with an SR-22 certificate of insurance, which he filed with the BMV. After the defendant had informed the applicant of the pending cancellation, the BMV returned a copy of the SR-22 to the defendant and requested the applicant’s name and address be added to the form as only his social security number and date of birth had been filled out. The court held that coverage existed as a matter of law because the SR-22 certificate of insurance was filed with the BMV, but the insurance company never filed the statutorily required SR-26 notice of cancellation.


*Jury’s Finding of Intentional/Malicious Act in Assault Case Precluded Coverage Even Though Plaintiff and Defendant Stipulated to Defendant’s “Negligence”*

Plaintiff brought suit following an altercation at a party while both the plaintiff and the defendant were attending the University of Dayton. As a result of the altercation, plaintiff suffered personal injuries and sued defendant for damages. Defendant sought defense and indemnification coverage under his parent’s insurance policy, but the insurer intervened, asking the court to determine there was no coverage afforded in this case on the basis of the policy’s intentional acts exclusion, because the defendants actions were arguably willful and malicious the jury returned a verdict in favor of plaintiff, and found that the defendant’s conduct was willful and malicious. The trial court held in favor of the insurer, and plaintiff appealed, and the trial court’s decision was agreed.
**Summary Judgment in Favor of the Insurer was Improper Regarding Resident of Household Clause**

Plaintiff’s underage daughter lived with the defendant and the defendant’s spouse for almost a year before the defendant’s spouse demanded the daughter move out. The defendant and the plaintiff’s daughter stayed in a hotel for a few days before moving in with the plaintiff. Soon after, the plaintiff discovered the defendant was in an inappropriate relationship with her daughter and brought suit on her daughter’s behalf. The defendant’s homeowner’s insurer intervened and moved for summary judgment on its declaratory judgment claim that it had no duty to defend or to indemnify the defendants in the lawsuit because of a policy exclusion for claims brought by one insured against another. The court found summary judgment in favor of the insurer was improper because there were genuine issues of material fact regarding whether the plaintiff’s daughter was a “resident” of the defendant’s household or “under the defendant’s care” after the daughter and defendant moved out of the home.


PTSD and Injuries Arising Therefrom do Not Constitute a “Bodily Injury” for Coverage Purposes Under an Auto Liability Policy

Defendant was walking with her sister when a pick-up truck struck and killed the defendant’s sister. Following the incident, the defendant was diagnosed with Post Traumatic Stress Disorder (PTSD) and brought suit against the tortfeasor. The tortfeasor’s automobile insurer filed a declaratory judgment action to exclude defense and indemnification coverage asking the court to declare that PTSD was not a “bodily injury” for coverage purposes. The court held that bodily injury under the policy – defined as “bodily harm, sickness or disease, including death that results” – does not include PTSD-related injuries.


No Duty for Insurer to Defend Against Claims That Will Certainly be Excluded From Coverage

Plaintiff insured property owned by defendant. Two purchasers of the properties sued defendant arising out of issues that had been occurring before defendant had purchased the insurance policies from plaintiff. Plaintiff moved for summary judgment on the grounds it had no duty to defend claims that were outside of the coverage period. The trial court granted the motion. Defendant appealed, and the appellate court agreed, holding the insurer’s policies indicated that the claims brought about in suit against defendants would never fall under the plaintiff’s coverage, and there was no duty to defend against these claims by insurer.

Policy Issued to Bar Owner Did Not Exclude Coverage for Injury Sustained by Patron Caused by Bouncer Who Claims He Struck Plaintiff in Self Defense

An altercation occurred at defendant’s bar in which an employee of defendant, claiming self-defense, struck the plaintiff in the jaw resulting in serious injury. Plaintiff sued, and defendant’s insurer intervened for the purpose of interposing a declaratory judgment action seeking a declaration the bar’s insurance policy did not provide defense or indemnification coverage because the employee’s “assault” upon the patron was excluded. The trial court’s award of summary judgment in favor of the insurer was reversed on appeal because genuine issues of material fact existed regarding whether 1) the defendant employee was actually acting within the course and scope of his employment at the time of the event, and 2) whether the employee’s use of force was a legitimate act of self-defense.


Interpretation of Medical Payments Coverage Clause

Plaintiff brought suit following the defendant’s attempt to subrogate against plaintiffs for the medical payments made on behalf of the defendant. Plaintiff claimed the defendant was paying a higher rate than was negotiated by plaintiff’s own insurance company. The trial court granted defendant’s motion for summary judgment, stating that defendant lacked access to the negotiated rates charged to plaintiff’s own insurance company because defendant was not a part of those contracts. Plaintiff appealed and the court reversed stating there were genuine issues of material fact as to whether defendant had reasonable access to the reduced negotiated rates.


The “Last Antecedent” Rule Does Not Apply to an Underinsured Motorist Policy of Insurance

Plaintiff was injured as a passenger while riding in his son-in-law’s car in an accident caused by another driver. After recovering from the tortfeasor and from plaintiff’s own underinsurance auto policy, plaintiff sought to recover as an “insured” under his son-in-law’s UIM policy. The UIM insurer argued plaintiff was not an “insured” under the policy. In rejecting plaintiff’s argument, the trial court held that the policy was unambiguous and granted defendant insurer’s motion for summary judgment. On appeal, the court held that because the “last antecedent” rule of construction did not apply to this policy of insurance, plaintiff was not an “insured” for UIM purposes, and not entitled to UIM coverage.
Insurance Contract Must be Ambiguous in Order to Construe Liberally in Favor of Insured

Defendant was moving hay on a farm when the elevator collapsed and injured defendant and his son. Defendants claimed that they were covered under the insurance policy, and plaintiff sought declaration that plaintiff was under no obligation to provide insurance coverage. The trial court granted declaratory judgment, stating that the defendants were not engaged in business activities and, as such, were not covered. Defendants appealed, and the court agreed, stating that the insurance policy would not be construed in favor of expanded insurance coverage because the language was not ambiguous.

Insufficient Business Personal Property to Conduct Customary Operations Indicates Vacancy

Plaintiff denied coverage to defendant’s theft-loss claim under a Premium Business Owners Policy of Insurance on the grounds the defendant’s property was vacant under the terms of the policy when the loss occurred. Defendant maintained all the fixtures, machines, and equipment necessary to perform the customary business activities of a commercial bakery, but the building did not contain any of the raw materials or finished products which are necessary for customary bakery operations. The court held that for a building occupied by a tenant to not be vacant under the policy, it must contain a sufficient quantity of fixtures, machines, equipment, and stock for the business to conduct customary business activities. Because the defendant did not have enough raw materials on site for it to produce any baked goods, the defendant’s building was vacant under the policy.

No Duty to Defend Insured When Actions Were for Personal Reasons Not Business Conduct

Plaintiff filed civil conspiracy claims against defendant regarding false allegations made to police. Defendant’s insurer filed a motion to intervene and sought declaratory judgment that it had no obligation to the defendant under the commercial policy. The trial court granted the insurer’s motion for summary judgment on the grounds that the allegations leveled against the defendant were outside the scope of business conduct. The court agreed, stating that the insured’s alleged actions were of a personal nature, and not conducted in the scope of business.

Summary Judgment Improper When Dispute Exists Surrounding Delivery of Policy

Defendant insured plaintiff’s rental property during the period the property incurred fire damage. Plaintiff notified the defendant of the fire damage, and the defendant denied the claim because of the policy’s vacancy exclusion. The plaintiff filed breach of contract and bad faith claims, and the defendant responded with a motion for summary judgment on the basis of the policy exclusion. The court held summary judgment was improper because the plaintiff alleged he never received a copy of his policy, which created a genuine issue of material fact as to whether the plaintiff was bound by the vacancy exclusion.


Summary Judgment Dismissing Bad Faith Claim Appropriate Where Plaintiff is Not Entitled to Coverage

Defendant denied coverage of plaintiff’s fire loss claim after concluding the fire was caused intentionally by plaintiff’s mentally ill son. Plaintiff’s son pled guilty to attempted arson, but he testified he had no recollection of events preceding the fire. Hospital records revealed he had a blood alcohol concentration of .22, and marijuana, cocaine, and benzodiazepines in his system the night of the fire. The court held 1) an insured’s voluntarily intoxication does not render an otherwise intentional act unintentional such that it entitles the insured to coverage under an insurance policy that excludes coverage for intentional acts; 2) a juvenile adjudication can be considered in determining whether conduct constitutes an intentional act or a criminal act; 3) the Daubert test does not prohibit an expert’s opinion that a fire was intentionally set when the conclusion was formed from an NFPA-compliant investigation that included a personal inspection of the fire site, interviews with the plaintiff, and systematic elimination of other potential causes of the fire; 4) trial courts have discretion to refuse to submit a party’s requested interrogatories to the jury when the opposing party’s interrogatories address the same issues; and 5) a plaintiff cannot make a bad faith claim when the plaintiff fails to satisfy its burden of showing that it is entitled to coverage.

Schaefer v. Musil, 9th Dist. Summit No. 27109, 2014-Ohio-1504

Genuine Issue of Material Fact as to Whether a Push Was an Occurrence

Defendant pushed plaintiff, who fell down, and was injured. Plaintiff sued. Plaintiff’s insurer filed a motion to intervene seeking a declaration it had no obligation to the defendant under the policy. The trial court granted the insurer’s motion for summary judgment on the grounds the incident was not a covered occurrence because it was not an “accident.” The appellate court reversed, holding there was a genuine issue of fact regarding whether the defendant’s “push” could have reasonably been expected to result in plaintiff being injured, precluding summary judgment.
Insured Not Entitled to Coverage for Allegedly Stolen Items Where Policy Requires Insured to Produce Physical Evidence to Show What Happened to the Property

Plaintiff alleged items were stolen by an employee at his business, then filed a claim under his business insurance policy. The insurer denied the claim on the basis loss of property due to criminal acts by employees is not covered under the policy. Plaintiff sued the insurer for breach of contract. The trial court granted defendant insurer’s motion for summary judgment on the basis the incident regarding stolen property was explicitly excluded from coverage on the basis of the “physical evidence” requirement relating to missing goods. The appellate court agreed, holding the “physical evidence” requirement did not result in illusory coverage.


Defendant gave permission to his employee to take defendant’s car home overnight and return it in the morning. The employee reached home, got drunk, got back in the car to go to the store, but caused an accident on the way which killed one and injured two others. Plaintiff, the employer’s insurer, filed a declaratory judgment action seeking a declaration it had no duty to defend and indemnify the employee in connection with the resulting wrongful death action because the employee did not have permission from the employer to get drunk and get back in the car. The insurer’s motion for summary judgment urging adoption of the “initial permission rule” in Ohio was rejected by the trial court. The appellate court agreed, noting that since the owner of the vehicle did not limit it for specific use, there was not a complete departure or gross deviation from the initial grant of permission.


While a Policy of Insurance May Not Provide Coverage for Defective Workmanship, the Policy May Provide Coverage for Consequential Damages Arising From an Insured’s Work

Plaintiff and defendant insurers consecutively insured an electrician who wired a new home which burned to the ground after the electrician went out of business. The homeowners (HO) were compensated under their homeowners’ policy, and the HO insurer filed a subrogation action against the electrician for damages devolving from negligent wiring. Plaintiff insurer settled on behalf of the electrician with the HO carrier, then sued the defendant insurer for contribution. The parties filed motions for summary judgment, and the trial court concluded the defendant’s policy did not provide coverage (and would not be liable for contribution) because the damage to the home did not occur during the policy period. The appellate court disagreed, holding that based upon the allegations in the subrogation complaint, it was possible the damage could have been caused, in part, during the policy period covered by the defendant’s policy.
When Choosing to Decline Corporate Liability Coverage for Employees Driving Non-Company Cars, Employers are Self-Insuring and Cannot Recover Against the Insurance Agent/Broker for Failing to Secure Adequate Auto Coverage

Plaintiff employer elected not to continue its corporate liability coverage for employees not driving company owned vehicles. Three years later, plaintiff’s employee struck and killed two individuals while driving a non-owned vehicle while acting in the course of employment. Plaintiff voluntarily settled with the victims’ representatives. Plaintiff then filed suit against defendant insurance agency for negligence, breach of fiduciary duty, and vicarious liability for failing to secure for plaintiff adequate coverage. The trial court granted summary judgment for the defendant, and plaintiff appealed. On appeal, the court agreed with the defendant insurance agency and held that plaintiff clearly knew, and had appreciation for, the known risk of employees driving hundreds or thousands of miles in motor vehicles not covered by the liability insurance.

Expert Opinions Must be Supported by Competent Evidence

Plaintiff owns and manages the common area of a condominium complex which contains seventeen commercial units in one building. The plaintiff claimed there was hail damage to the roof from a storm, and filed a notice of claim with defendant insurer. Based upon its expert’s opinion, defendant determined the damage was not caused by hail and, as such, there was no coverage for the claim under the policy. Each party submitted expert affidavits in support of, and in opposition to, the motion. In granting the insurer’s motion, the court determined the plaintiff’s expert’s opinions were not expressed to a reasonable degree of scientific probability and, as such, were conclusory in nature, and insufficient to create a genuine issue of material fact to preclude summary judgment.

Two Year Requirement Contained in Policy of Insurance for Filing Action Against Insurer Upheld

On October 18, 2010, a theft occurred at a facility owned by the plaintiff where the thieves broke an office window and stole copper piping and electrical wiring, in doing so they also damaged that to which it was attached. The plaintiff business was insured by defendant insurer under a commercial liability policy. The commercial liability required the insured to bring any action against the insurer by the insured within two years. Plaintiff filed its lawsuit against the insurer on October 26, 2012, outside the 2-year limitation period. The insurer filed its motion for summary judgment seeking dismissal of the lawsuit on this basis, the trial court granted the motion, and the trial court’s decision was upheld on appeal.
An Insured’s Vandalism Claim is Subject to Principles of Judicial Estoppel

Plaintiff homeowner filed a vandalism claim arising from a home break-in. Plaintiff filed bankruptcy and valued his personal property loss at $3,100.00. Later, Plaintiff sued defendant insurer for breach of contract and insurer bad faith, alleging, among other things, the value of the personal property loss at $155,678.65. Defendant filed a dispositive motion seeking dismissal of the breach of contract and bad faith claims. The motion was granted. On appeal, the court 1) affirmed the trial court’s decision that principles of judicial estoppel precluded the insured from recovering more than $3,100.00, and 2) overruled the trial court’s dismissal of the bad faith claim because a jury could very well conclude the failure of the insurer to promptly pay the $3,100.00 to the insured might constitute insurer bad faith.

b. UM/UIM Decisions

*Barnes v. Thompson*, 7th Dist. Columbiana No. 12 CO 26, 2013-Ohio-5886  

**Plaintiff’s Police Cruiser Not Entitled to UM/UIM Coverage**

Plaintiff was injured following a motor vehicle accident while working as a police officer and driving a police cruiser owned by the city. Plaintiff’s medical costs were covered by workers compensation, but the vehicle plaintiff was driving at the time of the accident did not have UM/UIM coverage. Defendant’s insurer stated there was no coverage for the vehicle because he was driving a vehicle he did not own, but that he used for his regular use. The trial court granted the insurer’s motion for summary judgment, and the appellate court agreed, holding that the plaintiff’s operation of the police cruiser fell under the “regular use” exclusion.


**Failure to Wear a Helmet Does Not Establish Basis for Negligent Entrustment**

Following an accident with a four-wheeler, plaintiff filed a negligence action, as well as a negligent entrustment action, against the defendant’s mother. The trial court granted summary judgment in favor of the defendant, holding that no genuine issue of material fact existed with respect to the issue of whether defendant’s son had reckless or negligent tendencies. The appellate court agreed, holding the boy’s failure to wear a helmet does not establish incompetence or a lack of qualification, and defendant’s mother had no control of the four-wheeler because it was owned by her live-in boyfriend.

Regular Use Exclusion of Uninsured/Underinsured Motorist Coverage Upheld

Defendant’s vehicle struck plaintiff’s parked work vehicle while the plaintiff was working for USPS. Plaintiff made an underinsured claim against his insurer, which the insurer refused on the basis that the plaintiff was driving a vehicle given to him by his employer furnished to him for defendant for his “regular use.” The trial court granted the insurer’s motion for summary judgment on the basis that exclusion of coverage was proper. The appellate court agreed, stating that underinsured/uninsured motorist coverage is not applicable to all vehicles. Specifically, coverage was not applicable to the plaintiff’s work vehicle because it fell under the “regular use” exception of the policy.

c. Employment Decisions


Termination for Just Cause Eliminates the Possibility for Receiving Unemployment Benefits

Plaintiff was suspended once by his employer for causing a scene and using inappropriate language. After a second similar incident, plaintiff was terminated for breaching company policy. Because he was terminated for cause, plaintiff was denied unemployment benefits, and he appealed this decision from the administrative hearing level through the Ohio Eighth District Court of Appeals. The appellate court determined that plaintiff was not entitled to unemployment benefits because he had been terminated for just cause because the evidence indicated the employer’s policy was uniformly applied.

Smith v. Ray Esser & Sons, Inc., 2013-Ohio-1095

Post-Accident OSHA Citations are Admissible for the Purpose of Proving an Employer’s Intent to Injure Under R.C. 2745.01(B) in an Employer Intentional Tort Action

Plaintiff was injured while replacing a fire hydrant in a trench when a hidden, buried mechanical compression joint failed and separated, shifting the assembly, pinning the plaintiff’s hand, and flooding the trench. Plaintiff was rescued by the employer, but plaintiff sued the employer for employer intentional tort. The employer was cited by OSHA following the accident for violating a safety regulation which would not have prevented the accident or injury. Summary judgment was granted to employer by the trial court on the basis there was no evidence the employer deliberately intended to injure the employee, an element required to be proven in an employer intentional tort case, under R.C. 2745.01(B). Nevertheless, the appellate court reversed, holding that evidence of post-accident OSHA citations, even if unrelated to the injury, was admissible for the purpose of demonstrating employer’s intent to injure under R.C. 2745.01(B).
An Employee Must Support a Race Based Retaliatory Discharge Claim With Specific and Credible Evidence

Plaintiff, an African American, was discharged by defendant employer for poor performance. Plaintiff sued the defendant claiming the discharge was in retaliation for plaintiff’s complaint of racial discrimination. The trial court concluded, and the appellate court agreed, plaintiff’s claims were insufficient to withstand the employer’s motion for summary judgment because plaintiff failed to establish, with clear evidence, he was discharged for engaging in a “protected activity” in the first instance, i.e., that he complained to company officials he was being discriminated against on the basis of race. The appellate court agreed, and held the claim of racial discrimination was vague at best and, as such, there was no “retaliatory discharge” as matter of law.

A Terminated Employee Who Files a Wrongful Discharge Lawsuit Must Prove, Among Other Things, Such Termination Violates a Clear Public Policy

Plaintiff’s employment was terminated by the defendant for exhibiting an abusive management style. Plaintiff sued the employer for wrongful discharge, arguing that while her employment was “at will,” her suit was proper because her termination violated “a clear public policy.” Unfortunately for plaintiff, she neglected to articulate the public policy allegedly violated with any specificity, and the employer’s award of summary judgment dismissing the lawsuit was upheld on appeal.

d. Premises Liability Decisions

Landlord Not Liable for Injuries Caused by Tenant’s Dog

Plaintiff brought suit, following a dog bite, against the renters of a home and the homeowners of the home. Plaintiff alleged the property owners had provided sufficient notice of the dog on the premises due to a “Beware of Dog” sign in the window. The trial court granted the defendant’s motion for summary judgment on the basis there was no evidence to demonstrate that the homeowners had any knowledge that the dog existed or was vicious. Plaintiff appealed and the court upheld the trial court, stating that neither the existence of the sign nor the homeowners failure to register the property as a rental was sufficient to create a genuine issue of material fact to preclude summary judgment.
Plaintiff Cannot Recover Damages From a Store Owner for Personal Injuries Sustained in a Fall Caused by an Open and Obvious Condition in the Absence of Attendant Circumstances

Plaintiff fell in a hole in the sidewalk adjacent to defendant’s store, was injured, and sued defendant. The defendant filed a motion for summary judgment on the basis the hole was open and obvious. The trial court granted the motion. Upon appeal, the court agreed with the trial court, noting that walking from a store to one’s car in a parking lot containing moving vehicles and other pedestrians is insufficient to constitute an “attendant” circumstance which would preclude operation of the “open and obvious hazard” defense.

In a Premises Liability Case, “Darkness” is an Open and Obvious Hazard Which Precludes Recovery of Damages for Personal Injury Resulting From a “Fall in the Dark”

Plaintiff fell down an unlit staircase at defendant’s bed and breakfast, resulting in injury. Plaintiff sued the defendant, which filed a motion for summary judgment on the basis the plaintiff was injured as a result of an open and obvious condition (“darkness”) existing upon the property. The motion dismissing the lawsuit was granted by the trial court, and upheld on appeal.

A Store Owner Complies With Its Duty to Inspect if Such Inspection Occurs at Thirty Minute Intervals

Plaintiff slipped and fell in defendant’s store in a puddle of bright yellow liquid, and was injured. Plaintiff sued the defendant for personal injuries, and defendant filed a motion for summary judgment on the basis the hazard was open and obvious. The motion was granted. On appeal, the court agreed, holding 1) the puddle was open and obvious, and 2) a gap of 30 minutes between the time the floor was last inspected (swept) by defendant and the time of the plaintiff’s fall was insufficient to establish the defendant had constructive notice of the hazard, which otherwise would have precluded summary judgment on the basis of the “open and obvious” defense.
e. Governmental Immunity Decisions


Summary Judgment Regarding Whether the Firefighter’s Conduct Was Wanton or Reckless Inappropriate Based Upon a Totality of the Circumstances

Defendants’ fire truck proceeded through a stop sign at a blind intersection and collided with a minivan, resulting in the deaths of plaintiff’s husband and grandson. Under R.C. 2744.02(B)(1)(b), an employee responding to a fire emergency negates the immunity of the political subdivision by causing injury through willful or wanton conduct, and negates the employee’s immunity by causing injury through wanton or reckless conduct. Defendants filed a motion for summary judgment based upon governmental immunity, which was granted. The appellate court reversed the decision on the basis that reasonable minds could come to differing conclusions as to whether the firefighters in this case acted wantonly or recklessly.

*Fedarko v. City of Cleveland*, 8th Dist. Cuyahoga No. 100223, 2014-Ohio-2531

City Not Immune for Injury From Defective Manhole Cover Located on Sidewalk Because Maintenance of the City’s Water System Was a Proprietary Rather Than a Governmental Function

Plaintiff was injured when she stepped on a manhole cover located on the sidewalk. The manhole cover gave way, causing her to fall up to her waist into the abandoned water meter vault that was beneath the sidewalk. The city asserted it was entitled to immunity under R.C. Chapter 2744 because the manhole cover was part of the sidewalk and the maintenance and repair of the manhole was a governmental function. Plaintiff argued the manhole cover and water meter vault were part of the city’s water system and the upkeep should be considered a proprietary function of the city. The court examined several cases dealing with the injuries from manholes and poorly maintained sidewalks, and held the water meter vault and cover were part of the city water’s system and thus fell within the proprietary function exception to immunity contained in R.C. 2744.02(B)(2).


Immunity Exception Does Not Apply Where Injury Occurs on Road Maintained by Government

Plaintiffs sued defendant County alleging the condition of the road, which was under construction, caused plaintiff’s daughter to lose control of her vehicle and collide with a tree, resulting in her death. The trial court granted defendant’s motion for summary judgment under R.C. 2744.02, claiming immunity. Plaintiff appealed, arguing under 2744.02(B)(3) political subdivisions are liable for injury, death, or loss to person or property caused by their failure to keep public roads in repair and other negligent failure to remove obstructions from public roads. The court held that since the County Engineer paved over the white lines and added an additional
layer of asphalt that resulted in an edge drop of approximately 4 1/2 or 5 inches, the County could be held liable for negligent failure to keep the road in repair under R.C. 2744.02(B)(3).

Ponyicky v. Schemerich, 9th District 2014-Ohio-3540

Whether a “Borrowed” City Bus Driver is an “Employee” or an “Independent Contractor” is a Jury Question

Plaintiff’s car was rear ended by bus driver employed by Medina County Public Transit who was driving a bus for the City of Brunswick pursuant to a contract between the governmental entities. Plaintiff sued the defendant and the City for negligence, and the City moved for summary judgment on the basis of governmental immunity, i.e., the driver was not employed by Brunswick at the time of the accident, but rather an “independent contractor.” The trial court determined, and the appellate court agreed, genuine issues of material fact existed regarding the issue of whether the bus driver was an “employee” or an “independent contractor” and denied the City’s motion for summary judgment.

Lane v. Greater Cleveland R.T.A., 2014-Ohio-3917

The Employer of a City Bus Driver Who Assaults a Passenger is Immune From Liability Unless the Passenger Alleges and Proves the City’s Decision to Hire the Driver Was Malicious, Willful, or Wanton

Plaintiff passenger entered into a confrontation with the driver of one the defendant’s buses. Plaintiff sued. The trial court dismissed plaintiff’s claim against the bus driver’s employer, and the plaintiff appealed. The appellate court held the employer was immune as a matter of law because plaintiff failed to allege sufficient facts to negate the employer’s immunity defense under R.C. 274.03(A)(5).

Combs v. Ohio Dept. of Natural Resources, 2014-Ohio-4025

Ohio’s Recreational User Statute (R.C. 1533.181(A)(1)) Does Not Apply Where the Injury Was Not Caused by a Defective Condition Existing on Land, but From Another’s Negligence

Plaintiff was struck in the eye by a rock that was launched in the air by mower being operated by an employee of the defendant state actor. Plaintiff sued defendant alleging negligent mowing. The trial court ruled the defendant was immune from liability because plaintiff was a recreational user injured on the defendant’s premises. On appeal, the court held plaintiff’s injury did not devolve from a defective condition existing upon the premises and, as such, immunity under the Ohio Recreational User Statute was inapplicable.
Hawsman v. Cuyahoga Falls, 2014-Ohio-4325

An Indoor Swimming Pool Operated and Maintained by a City is Not Immune Under R.C. Chapter 2744 Because it is Considered a Building Used in Connection With a Government Function

Plaintiff nine year old boy sued defendant City, claiming the City negligently maintained the swimming pool and diving board in a natatorium housed in a City building. The defendant filed a motion for summary judgment claiming it was statutorily immune from suit and that the exception under the immunity statute [2744.02(B)(4), which states that a political subdivision can be held liable for injury caused by the negligence of its employees that occurred within the grounds of buildings used in performing a governmental function] did not apply to indoor swimming pools. The court of appeals held the statutory exception to immunity does apply to indoor swimming pools housed in a building used in connection with the performance of governmental functions.

Doe v. Bath Local School Dist., 2014-Ohio-4992

A Bus Driver’s Failure to Supervise the Students on Her Bus Does Not Constitute Negligent Operation of a Motor Vehicle

Plaintiff is the mother of a five year old daughter who claims she was sexually assaulted on a school bus by another student, a seventeen year old boy. Plaintiff sued the school for negligent supervision, and claimed such negligent supervision constituted negligent operation of a motor vehicle for which the District would not otherwise be immune under R.C. Chapter 2744. The District argued negligent supervision does not constitute “negligent operation” of a motor vehicle as a matter of law. The appellate court held that the school bus driver’s failure to supervise does not constitute “negligent operation of a motor vehicle” as contemplated by the exception to governmental immunity set forth in R.C. 2744.02(B)(1) and, as such, the District was immune from liability for “negligent supervision.”

f. Other Significant Decisions


Defendant Insurer Found to be Liable to Pay Settlement Damages Following Trial

Plaintiff filed a negligence complaint against his employer, TCC, a cable company hired by Time Warner to perform cable work in Zanesville. Plaintiff fell off a ladder and sustained serious injuries. TCC was insured under a combined workers’ compensation and employers liability policy issued by Lumberman’s with a policy limit of $1,000,000.00, and a comprehensive general liability policy issued by a second insurer, Ohio Casualty, which provided a $1,000,000.00 liability coverage. Plaintiff also sued Time Warner, which was ostensibly covered under Ohio Casualty’s policy, as well as a commercial general liability policy issued by Travelers. TCC was also covered under a $5,000,000.00 umbrella policy issued by appellant that
contained employers’ liability coverage if the primary policy issued by Lumbermen’s so provided. After settling with Time Warner for $850,000 and receiving a default judgment award against TCC for $4,000,000, plaintiff filed supplemental petitions against Ohio Casualty and Lumbermens to recover the unsatisfied portion of the judgments. The court agreed with the trial court’s finding that Time Warner was an additional insured under Ohio Casualty’s policy issued to TCC, ordered Ohio Casualty to pay its share of the settlement with Time Warner, and determined Travelers was not responsible to contribute to the payment. The court also ordered Lumbermens to pay the first $1,000,000 owed by TCC under its employer’s liability policy, and ordered Ohio Casualty to pay the remaining $3,000,000 judgment against TCC under its umbrella policy.


An Insurance Policy Created in Michigan Will Apply Michigan Law in Litigation Involving Its Insured

Plaintiff is the subrogated insurer of the driver of a motor vehicle injured in an Ohio accident caused by the negligence of a Michigan resident. Plaintiff sued defendant, who moved for summary judgment to dismiss the case because the same matter was being litigated in Michigan. The motion was granted and the appellate court agreed, holding Michigan law should apply.


Date of Direct Physical Loss Fell Outside of Two Year Statute of Limitations

Plaintiff experienced computer problems intermittently for a period of time, until the problems peaked, resulting in the plaintiff’s servers and computers being inoperable. More than a year after the peak of the computer problems, the plaintiff contacted the defendant about filing a claim for the losses resulting from the computer problems. The defendant insurer denied plaintiff’s claim, and plaintiff sued defendant for breach of contract, unjust enrichment, bad faith, and fraud. On appeal, the court held that the date of direct physical loss occurred at the time the computer problems “peaked,” i.e., at the time when plaintiff’s computers became inoperable. Because the complaint was filed after twenty-five months, beyond the two-year contractual limitations period for bringing an action against the insurer under the policy, the insurer was entitled to judgment on the pleadings.
Implied Indemnification is Not Available to an Insurer Against an Insurance Agent Who Negligently Cancelled a Policy Where the Insurer Settles With the Insured and Sues the Broker for Complete Reimbursement for the Settlement Proceeds

Plaintiff insurer sued defendant insurance broker after plaintiff settled an insurance claim out of court. Suit alleged that defendants were complicit in wrongly denying insurance coverage to a client and should be made to reimburse the insurer in the amount of the original settlement under principles of implied indemnification. The trial court granted summary judgment for defendants, stating that defendants could not be made to pay for this prior settlement. Appellate court agreed, holding that because the prior action was resolved through a settlement, and not through a judgment imposed upon the insurer based on its “fault” in creating the liability, principles of implied indemnification were unavailable to the insurer in the action against the broker as a matter of law.

Standard Explained in Determining Beneficiaries for Life Insurance Policy

Owner of life insurance policy named both plaintiff and defendant as beneficiaries. Though the owner of the policy attempted to change the beneficiaries of the policy, none of the paperwork was turned in. When the owner of the policy died, both plaintiff and defendant claimed entitlement to the proceeds. The insurer placed the money into an account to be held by the trial court, and claimed no interest in the proceedings. Trial court granted summary judgment to defendant, holding that defendant was the primary beneficiary. The appellate court disagreed, stating that evidence of the owner’s intent to change beneficiaries superseded other formalities.

Ohio’s Equine Activity Immunity Statute Supersedes Ohio’s Strict Liability Dog Statute

Plaintiff prospective horse purchaser was knocked down by a horse in a stall that had been spooked by a barking dog which had entered the stall and nipped at the horse’s rear legs. The plaintiff sued the dog owner (who also owned the stable) under R.C. 955.28, which makes a dog owner strictly liable for injuries caused by dogs. Defendant argued the immunity afforded by Ohio’s Equine Activity Statute, R.C. 2305.321, applied. On appeal, the court agreed the latter superseded the former, and found for the stable owner.
3. Federal Court Decisions

http://www.ca6.uscourts.gov/opinions.pdf/14a0729n-06.pdf


Plaintiff was fired from one of the defendant’s restaurants for a scene she caused while arguing with the manager. After she was fired, plaintiff called the District Manager who then investigated and came to the conclusion that the plaintiff deserved to be fired. Plaintiff filed suit claiming race and gender discrimination. On appeal, the court determined, based upon the evidence, plaintiff could not demonstrate she was qualified for the job, that she was replaced by someone outside the protected classes, and that even if she could make out a prima facie case of discrimination, dismissal of the action was warranted because the evidence demonstrated the employer’s reasons for dismissing plaintiff were substantive and not merely pretextual, i.e., plaintiff was a low performer and often lost her “cool” in front of customers.

Rose v. State Farm & Casualty Company, No. 13-3887

Whether a Homeowner Intentionally Withheld Information From the Insurer During a Fire Investigation Presents an Issue of Fact for the Jury

Plaintiff’s home was destroyed by fire. The insurer’s investigation suggested arson. During the subsequent investigation, the insured failed to disclose certain financial and legal information which may have suggested plaintiff had a motive to set the fire, and the insurer denied the claim. Plaintiff sued, and the trial court granted the defendant insurer’s motion for summary judgment. The appellate court reversed, indicating there were genuine issues of material fact regarding whether the insured intentionally withheld the information, as required by the policy.
D. Significant Cases Pending Before the Ohio Supreme Court


When a Dismissal Entry is Unconditional

This appeal considers whether a dismissal entry that does not either embody the terms of a settlement agreement, or expressly reserve jurisdiction to the trial court to enforce the terms of a settlement agreement, is an unconditional dismissal.

Smith v. Chen, 2014-Ohio-1182

Whether Plaintiff Established Good Cause for Discovery of Surveillance Video

This appeal reviews the appellate court’s decision to compel the defendant to disclose surveillance video protected by the work-product privilege and considers whether the plaintiff established good cause by demonstrating 1) the substance of the video, which possibly revealed the extent of the plaintiff’s injuries, was directly at issue in the case; 2) there was a compelling need to view the video before trial to ascertain the video’s quality and accuracy; and 3) the video was in the plaintiff’s sole control and could not be obtained elsewhere.

Dillon v. Farmers Insurance of Columbus, Inc., 2014-Ohio-2245

The Applicability of the Ohio Consumer Sales Practices Act to Insurers

This appeal considers whether the provisions of the Ohio Consumer Sales Practices Act addressing requirements for repair estimates apply only to repair shops, or if the provisions also apply to insurers.

Sallee v. Watts, 2014-Ohio-0727

Whether Operation of a Motor Vehicle Also Includes Failure to Supervise Children on a School Bus as it Pertains to the Immunity Exception

Plaintiff regularly rode the bus home from school. Instead of going in the house, she ran down the street with a friend, crossed the street, and was struck by the defendant school bus operator. Plaintiff’s mother brought suit against the bus driver and the employer school district for negligence. The trial court held defendants were not immune because the alleged negligence of the driver had nothing to do with driving the bus, but with the mother’s failure to supervise her child. The appellate court reversed, holding the driver was negligent and not entitled to immunity. The Supreme Court will determine if the supervision of children after they exit the bus constitutes operation of a motor vehicle under the immunity exception.
Lincoln Electric v. Travelers Casualty and Surety Company, et al., 2013-Ohio-1088

The Question of State Law Certified by the Federal Court on Appeal is: “May an Insured Who Has Already Accrued Indemnity and Defense Costs Arising From Progressive Injuries on a Pro Rata Basis Switch to Employ an “All Sums” Method to Aggregate Unreimbursed Losses and Thereby Reach the Attachment Point of One or More Excess Policies?”

Plaintiff settled with his insurance carrier, the defendant, and agreed the primary carrier need only pay a portion of the defense and indemnity costs incurred in the product claims. Plaintiff filed a declaratory judgment action in federal court against its excess carriers, seeking a declaration that those excess carriers pay defense and indemnity costs. Plaintiff argued that it was entitled to pursue excess coverage on an “all sums” basis under its umbrella policies without exhausting all of its primary coverage. Defendants argued that because the plaintiffs elected to allocate claims on a “pro rata” basis it could not switch allocation methods mid-stream and use an “all sums” approach.

These cases were pending at the time this summary was printed. To confirm whether the Supreme Court has issued a decision in any of these cases, we invite you to visit our website at http://www.smithrolfes.com.

THIS IS AN ADVERTISEMENT
IV. **THE COMMONWEALTH OF KENTUCKY**

A. **FREQUENTLY CITED KENTUCKY STATUTES**

1. **Automobile Insurance**

**K.R.S. § 304.9-503**

Types of Insurance That Rental Vehicle Agent may Handle at Company Office - Coverage is Primary Over Other Coverage

A rental vehicle agent may sell, solicit, or negotiate insurance at the rental vehicle company office for insurance that covers the risk of travel, including accident and health insurance, liability insurance, personal property insurance, roadside assistance, emergency sickness protection programs, and any other insurance incidental to the rental of a motor vehicle and approved by the executive director. The rental vehicle insurance will be the primary coverage over any other coverage which may be available to the renter or authorized driver covering the loss.

**K.R.S. § 304.20-020**

Uninsured Vehicle Coverage

No automobile insurance policy shall be issued unless it provides coverage for injuries caused by the owners or operators of uninsured motor vehicles. An insured shall have the right to reject such coverage in writing. The term “uninsured motor vehicle” shall be deemed to include an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability of its insured due to insolvency.

**K.R.S. § 304.39-010 - K.R.S. § 304.39-220**

Personal Injury Protection / No-Fault Coverage

Unless specifically waived by the purchaser of automobile insurance, every purchaser in Kentucky is entitled to basic reparation payments to be paid without proof of fault for automobile accident injuries. The maximum amount of benefits to be paid out under the coverage is $10,000.00 per accident. The amount will be allocated to cover economic losses that are attributable to: medical expenses, work loss, replacement service loss, survivor’s economic loss, and survivor’s replacement service loss.

Once the limits of the no-fault coverage have been met, an injured party may pursue a third-party claim against the tortfeasor. The threshold requirements in order to pursue such a claim are that the damages either exceed $1,000.00, or that the injury sustained is a permanent disfigurement, a fracture to the bone, a compound, comminuted, displaced or compressed fracture, loss of a body member, permanent loss of bodily function, or death.

**K.R.S. § 304.39-320**

Underinsured Motorist Coverage

A tortfeasor’s liability insurance is the primary coverage and the underinsured motorist coverage insurance is the secondary or excess coverage. Therefore, UIM coverage is payable only to the extent that judgment exceeds the tortfeasor’s liability coverage. *Kentucky Farm Bureau Mut. Ins. Co. v. Rogers*, 179 S.W.3d 815, 818 (Ky. 2005).
(1) Every insurer shall make available upon request to its insureds underinsured motorist coverage.

(2) If an injured person agrees to settle a claim with the liability insurer and the settlement would not fully satisfy the claim for personal injuries so as to create an uninsured motorist claim, then written notice of the proposed settlement must be submitted by certified or registered mail to all underinsured motorist insurers that provide coverage.

(3) The underinsured motorist insurer then has a period of thirty (30) days to consent to the settlement or retention of subrogation rights.

(4) The underinsured motorist insurer is entitled to a credit against total damages in the amounts of the limits of the underinsured motorist liability policies in all cases. Nothing, however, including any payments or credits, reduces or affects the total amount of underinsured motorist coverage available to the injured party.

2. Negligence, Other Torts and Contribution

K.R.S. § 44.072
Limited Waiver of Sovereign Immunity in Negligence Claims

It is the intent of the General Assembly to preserve the sovereign immunity of the commonwealth, except in limited situations set forth in the statute. Except as specifically indicated otherwise, the Board of Claims shall have exclusive jurisdiction to hear claims for damages against the commonwealth.

K.R.S. § 186.590
Minor’s Negligence Imputed to Person Signing Application or Allowing Him to Drive

Any negligence of a minor under the age of eighteen (18), who has been licensed upon an application as provided by K.R.S. 186.470, will be imputed to the person who signs the application and they will be held jointly and severally liable for any damages caused by the minor’s negligence. Motor vehicle owners who cause or knowingly permit a minor under age eighteen (18) to drive the vehicle on the highway, or who furnish a vehicle to the minor, will be jointly and severally liable for the damage caused by the minor.

K.R.S. § 405.025
Parent or Guardian Liable for Willful Damage to Property Caused by Minor

The parent or guardian of any minor, in his care and custody, against whom judgment has been rendered for the willful marking upon, defacing or damaging of any property, shall be liable for the payment of that judgment up to an amount not to exceed $2,500.00 and not to exceed $10,000.00 in a cumulative amount.

K.R.S. § 411.182
Comparative Negligence

Under an action brought for negligence, Kentucky apportions liability for a sustained injury in relation to each party’s degree of fault. As between the parties, the jury is required determine how much at fault each party was, and then apportion damages accordingly (i.e. pure comparative negligence). Comparative negligence will not bar an entire recovery by the
plaintiff, but will reduce the total amount of the plaintiff’s award in proportion to their degree of fault.

**K.R.S. § 411.186**  
Assessment of Punitive Damages

In any civil action where claims for punitive damages are included, the jury, or judge if the jury trial has been waived, shall determine concurrently with all the other issues presented whether punitive damages may be assessed.

In determining the amount of punitive damages to be assessed, the trier of fact should consider the following factors:

1. The likelihood at the relevant time that serious harm would arise from the defendant’s misconduct;
2. The degree of the defendant’s awareness of that likelihood;
3. The profitability of the misconduct to the defendant;
4. The duration of the misconduct and any concealment of it by the defendant; and
5. Actions by the defendant to remedy the misconduct once it became known to the defendant.

**K.R.S. § 411.190**  
Obligations of Owner to Persons Using Land for Recreation

An owner of land owes no duty of care to keep the premises safe for entry or use by others for recreational purposes, or to give any warning of a dangerous condition, use, structure, or activity on the premises to persons entering for such purposes.

Nothing in this section limits in any way any liability which otherwise exists for willful or malicious failure to guard or warn against a dangerous condition, use, structure, or activity.

**K.R.S. § 411.310**  
Statute of Repose

1. In any product liability action it shall be presumed that the subject product was not defective if the injury occurred more than five (5) years after the date of sale to the first consumer or more than eight (8) years after the date of manufacture.

2. In any product liability action it shall be presumed that the product was not defective if the design, methods of manufacture and testing conform to the generally recognized and prevailing standards or the state-of-the-art in existence at the time the design was prepared and the product was manufactured.

**K.R.S. § 411.310**  
Presumptions in Product Liability Actions

1. In any product liability action, it shall be presumed, until rebutted by a preponderance of the evidence to the contrary, that the subject product was not defective if the injury, death or property damage occurred either more than five
(5) years after the date of sale to the first consumer or more than eight (8) years after the date of manufacture.

(2) State of the Art Defense.

K.R.S. § 413.241
Liquor Liability

The consumption of intoxicating beverages, rather than the serving, furnishing, or sale of such beverages, is the proximate cause of any injury, including death and property damage, inflicted by an intoxicated person upon himself or another person.

No person holding a permit under K.R.S. 243.030, 243.040, 243.050, nor any agent, servant, or employee of the person, who sells or serves intoxicating beverages to a person over the age for the lawful purchase thereof, shall be liable to that person or to any other person or to the estate, successors, or survivors of either for any injury suffered off the premises including, but not limited to, wrongful death and property damage.

3. Insurance Fraud

K.R.S. § 227.220
Duties of State Fire Marshal and Chief State Building Official Relating to Fire Loss

Details actions the State Fire Marshal shall or may take in the event of a fire loss.

K.R.S. § 227.250
Duty of Insurers to Report Losses From Fire, Lightning, Hazardous Materials, Flammable Liquids or Explosions

Insurers must report to the State Fire Marshal loss or damage caused by fire, lightning, hazardous materials, and flammable liquids or explosions that occur in or on property insured by the insurer in a manner prescribed by the State Fire Marshal. The State Fire Marshal may waive the reporting if, in his discretion, the losses are unimportant due to the small amount involved and to save time and expense.

K.R.S. § 227.260
Records of Fire Inspections, Investigations and Losses

State Fire Marshal shall keep a record of all fire inspections, investigations and fire losses occurring in this state and of facts concerning them. The records shall be public except for limited circumstances.

K.R.S. § 227.370
Inspection of Property by Fire Chief or Other Department Personnel - Inspection and Investigation Reports

Fire department is authorized to inspect all property for the purpose of ascertaining and causing to be corrected any conditions likely to cause fire loss, or determining the cause or origin of any fire loss, or discovering any violation of a law or ordinance relating to fire prevention and protection.
K.R.S. § 304.12-230
Unfair Claims Practices Act
This statute imposes duties on insurers on both first-party and third-party insurance claims. Under the statute, claims are to be paid within thirty (30) days upon notice and proof of claim unless the insurer is able to demonstrate why the claim cannot or should not be paid. The statute imposes interest at an annual rate of twelve percent (12%) after the expiration of the thirty (30) day period. The statute also allows an insured to recover attorneys’ fees for violations of this statute.

K.R.S. § 304.14-100
Application as Evidence
If the insurer does not furnish a copy of the insurance application to the insured within thirty (30) days after the insurer has received written demand from the insured, then the application of insurance is not admissible in evidence in any action between the insured and the insurer that arises out of the policy.

K.R.S. § 304.14-110
Representations in Applications
All statements and descriptions in any application for an insurance policy will be deemed representations and not warranties. Misrepresentations, omissions, and incorrect statements will not prevent a recovery under the policy unless they are fraudulent, material to the acceptance of the risk or to the hazard assumed by the insurer, or if the insurer in good faith would not have issued the policy, issued it at a different premium rate, not have issued a policy in as a large amount, or would not have provided coverage for the hazard resulting in the loss if insurer had been informed of the true facts.

K.R.S. § 304.14-270
Forms for Proof of Loss Furnished
Upon written request by any person claiming to have a loss under any insurance contract, the insurer must provide forms of proof of loss to the insured. The insurer has no responsibility or liability for the completion of the proof of loss forms.

K.R.S. § 304.14-280
Claims Administration Not Waiver
Acknowledgment of the receipt of notice of loss or claim under the insurance policy, furnishing forms for reporting a loss or claim and receiving any such forms or proofs completed or uncompleted, investigating any loss or claim or engaging in negotiations for a possible settlement of a loss or claim, and making advance or partial payments under insurance policies, does not constitute a waiver of any provision of a policy or of any defense the insurer may assert.
K.R.S. § 304.20-160
Power of Authorized Agency to Require Insurer to Furnish Information Concerning Fire Loss

An authorized agency may require an insurer to release information or evidence in the insurer’s possession deemed important to the investigation of a fire loss of suspicious origin. Such information may include, but is not limited to:

1. Pertinent insurance policy information pertaining to such fire loss and any application for such a policy;
2. Policy premium payment records;
3. History of previous claims made by the insured;
4. Material relating to such loss or potential loss.

Furthermore, when an insurer has reason to believe a fire loss may be of other than accidental cause, the insurer shall notify, in writing, an authorized agency.

Any insurer, or person acting in its behalf, or authorized agency who in good faith releases information in compliance with this section, shall not be held civilly or criminally liable.

K.R.S. § 304.47-060
Immunity for Cooperation With Law Enforcement

Under this statute an insurer is immune from civil liability if it notifies law enforcement authorities of suspected insurance fraud.

K.R.S. § 304.47-080
Special Investigative Units

All insurers licensed in Kentucky must have a special investigative unit to investigate possible insurance fraud. The unit may be staffed either by employees of the insurer or individuals specifically contracted by the insurer to investigate.

4. Miscellaneous Statutes

K.R.S. § 304.1-090
“Principal Office” Defined

This statute defines “principal office” as the office from which the general affairs of the insurer are directed or managed.

K.R.S. § 304.14-060
Insurable Interest, Property

“Insurable interest” means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment. Contracts of insurance of property or of any interest in or arising from property are only enforceable for the benefit of those who have an insurable interest in the things insured at the time of the loss.
K.R.S. § 304.14-360
Construction of Policies
Every insurance contract will be construed according to the entirety of its terms and conditions as set forth in the policy, and as amplified, extended, or modified by any rider, endorsement, or application attached to and made a part of the policy.

K.R.S. § 304.14-380
Venue of Suits Against Insurers
Suits based on causes of action against an insurer upon an insurance contract must be brought in the county where the cause of action arose or in the county where the policy holder resides.

K.R.S. § 304.20-050
Arbitration Provision Not Binding
A provision agreeing to arbitrate any or all disputes contained in an automobile liability or motor vehicle liability insurance policy delivered, issued for delivery or renewed in Kentucky, is not binding upon the named insured or person claiming under him.

K.R.S. § 342.690
Exclusiveness of Workers’ Compensation Remedy
If an employer secures payments of Workers’ Compensation for his employees, the liability of the employer shall be limited to such Workers’ Compensation payments and shall be exclusive and in place of all other liability.

K.R.S. § 405.025
Parent or Guardian Liable for Willful Damage to Property Caused by Minor
The parent or guardian of any minor, in his care and custody, against whom judgment has been rendered for the willful marking upon, defacing or damaging of any property, shall be liable for the payment of that judgment up to an amount not to exceed $2,500.00 and not to exceed $10,000.00 in a cumulative amount.

K.R.S. § 411.182
Allocation of Fault in Tort Actions - Award of Damages - Effect of Release
In tort actions when more than one party is at fault, the court will instruct the jury to answer interrogatories, and if no jury, will make findings indicating the amount of damages each claimant would be entitled if contributory fault is disregarded, and the percentage of total fault of all parties. In determining the percentage of fault, the trier of fact will consider the nature of the conduct of each party at fault and the extent of the causal relation between the conduct and the damages claimed and the court will also determine the award of damages to each claimant in accordance with the findings and determine and state in the judgment each party’s equitable share of the obligation to each claimant. A release, covenant not to sue, or other agreement between the claimant and a liable person, will discharge the liable person from all liability for contribution but will not discharge the liability of other liable persons unless it so provides and the claim of the releasing person against other persons will be reduced by the released persons’ equitable share of the obligation.
**K.R.S. § 411.184**  
Definitions - Punitive Damages - Proof of Punitive Damages

Punitive damages include exemplary damages and are damages other than compensatory and nominal damage. They are awarded to punish and to discourage the defendant and others from similar conduct in the future. The plaintiff must prove by clear and convincing evidence that the defendant acted toward the plaintiff with oppression, fraud, and malice. Punitive damages will not be assessed against a principal or employer for the act of an agent or employee unless they authorized, ratified, or should have anticipated the conduct. Punitive damages are not available for a breach of contract.

**K.R.S. § 411.188**  
Collateral Source Payment Rule

Collateral source payments, except life insurance, the value of any premiums paid by or on behalf of the plaintiff for same, and known subrogation rights shall be an admissible fact in any civil trial.

**K.R.S. § 413.120**  
Actions to be Brought Within Five (5) Years

The following actions shall be commenced within five (5) years after the cause of action accrued:

1. An action upon a contract not in writing, express or implied.
2. An action for personal injuries suffered by any person against the builder of a home or other improvements. This cause of action shall be deemed to accrue at the time of original occupancy of the improvements which the builder caused to be erected.
### Kentucky Statutes of Limitations

<table>
<thead>
<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
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</thead>
<tbody>
<tr>
<td>Assault and Battery</td>
<td>One year from the date of assault and battery.</td>
</tr>
<tr>
<td>K.R.S. § 413.140</td>
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</tr>
<tr>
<td>Bodily Injury Claims</td>
<td>One year from the date of injury. This statute applies to injuries caused by acts of negligence as well as those caused by intentional acts. This statute does not apply to bodily injuries stemming from automobile accidents.</td>
</tr>
<tr>
<td>Other than from Automobile Accidents</td>
<td></td>
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<tr>
<td>K.R.S. § 413.140</td>
<td></td>
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<tr>
<td>Loss of Consortium</td>
<td>One year from the date of the incident.</td>
</tr>
<tr>
<td>K.R.S. § 413.140</td>
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</tr>
<tr>
<td>Medical Malpractice</td>
<td>One year from the time the injury is first discovered or in the exercise of reasonable care should have been discovered. Any action must still be commenced within five years from the date the alleged act of negligence occurred.</td>
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<tr>
<td>K.R.S. § 413.140</td>
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<tr>
<td>Malicious Prosecution</td>
<td>One year from the date of the incident.</td>
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<tr>
<td>K.R.S. § 413.140</td>
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<tr>
<td>Libel, Defamation, or Slander</td>
<td>One year from the date of the incident.</td>
</tr>
<tr>
<td>K.R.S. § 413.140</td>
<td></td>
</tr>
<tr>
<td>Wrongful Death</td>
<td>If a person dies before the expiration of the applicable statute of limitations, the action may still be brought by their personal representative so long as it is commenced within one year of the appointment of the representative.</td>
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<tr>
<td>K.R.S. § 413.180</td>
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<tr>
<td>Product Liability</td>
<td>One year from the date of the bodily injury.</td>
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<tr>
<td>K.R.S. § 413.140</td>
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<tr>
<td>Claim Type/Section</td>
<td>Statute Period</td>
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<td>--------------------------------------------------------</td>
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<tr>
<td>Bodily Injuries from Automobile Accident</td>
<td>Two years from the date of the accident or two years from the date of the last no-fault payment. Survivors and beneficiaries of a decedent have two years to make a claim for wrongful death.</td>
</tr>
<tr>
<td>K.R.S. § 304.39–230</td>
<td></td>
</tr>
<tr>
<td>Damage to Personal Property</td>
<td>Two years from the date of injury or damage.</td>
</tr>
<tr>
<td>K.R.S. § 413.125</td>
<td></td>
</tr>
<tr>
<td>Product Liability</td>
<td>Four years from when the breach occurs, regardless of the aggrieved party’s lack of knowledge of the breach if brought under a theory of breach of warranty.</td>
</tr>
<tr>
<td>K.R.S. §355.2-725</td>
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<tr>
<td>Claim Type/Section</td>
<td>Statute Period</td>
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</tbody>
</table>
| Breach of Contracts Not in Writing | Five years from the date the contract was breached.  
K.R.S. § 2305.10 |
| Trespass on Real or Personal Property | Five years from the date of injury or damage.  
K.R.S. § 413.120 |
| Fraud | Five years from the date the fraud was discovered, but per K.R.S. § 413.130 no more than ten years after the date the fraud was perpetrated.  
K.R.S. § 413.120 |
| Intentional Infliction of Emotional Distress | Five years from the date of the incident.  
K.R.S. § 413.120 |
| Bodily Injury Claims Against the Builder of a Home or a Person Making Improvements to a Home | This cause of action accrues at the time of original occupancy of the home, or occupancy after the improvements in question were made.  
K.R.S. § 413.120 |
| Statutory Claims | This applies to all claims for liability based upon a statute where no statute of limitations is provided by statute.  
K.R.S. § 413.120 |
| Bad Faith | Five years from the alleged act of bad faith.  
K.R.S. § 413.120(7) |
<table>
<thead>
<tr>
<th>Claim Type/Section</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Breach of Written Contracts K.R.S. § 413.090</td>
<td>Fifteen years from the date of the breach.</td>
</tr>
<tr>
<td>Claims of Minors and Incompetents K.R.S. § 413.170</td>
<td>The statute of limitations does not begin to run until the minor reaches the age of majority or the incompetent plaintiff becomes competent.</td>
</tr>
</tbody>
</table>
C. **Significant Kentucky Court Decisions**

1. **Supreme Court Decisions**

   a. **Insurance Coverage Decision**

   [http://opinions.kycourts.net/sc/2012-SC-000317-DG.pdf](http://opinions.kycourts.net/sc/2012-SC-000317-DG.pdf)

   **Mutual Mistake**

   The injured party was hurt in a motor vehicle accident while driving a truck for his employer insured under a fleet policy. The employer told the agent UIM coverage should be rejected wherever possible, but the agent did not relay this to the insurance. Nine days after the accident the insurer received the rejection of UIM coverage from the employer. Unaware of the rejection, the injured worker settled with the tortfeasor and entered into a Coots release. The trial court granted the insurer summary judgment limiting the coverage finding there was a mutual mistake in the issuance of the policy and the appellate court agreed. The Supreme Court overturned the decision, finding there was no mutual mistake; rather a “misunderstanding” between the parties in applying the test set out in *Abney v. Nationwide Mut. Ins. Co.*, 215 S.W. 3d 699, 704 (Ky. 2006) (quoting *Campbellsville Lumber Co. v. Winfrey*, 303 S.W.2d 284, 286 (Ky. 1957). The Supreme Court held the insurer failed to show the mistake was mutual, as the insurer intended to issue the UIM coverage and curing the mistake would prejudice an innocent third-party who settled with the tortfeasor in reliance on the initial policy with UIM coverage.

   b. **Other Significant Decisions**

   [http://opinions.kycourts.net/sc/2012-SC-000314-DG.pdf](http://opinions.kycourts.net/sc/2012-SC-000314-DG.pdf)

   **Immunity**

   Student, who was legally blind, fell off a set of bleachers that were not properly extended in a school gym. As a result of his injuries, a law suit was filed against the teacher and principals. The appellate court determined neither the teacher nor principals involved in the suit were entitled to qualified immunity as their duties were ministerial in nature. However, the Supreme Court disagreed and held the principals were entitled to immunity. The Supreme Court held the school principals had qualified immunity because the responsibility to look out for student safety is a general duty, and requires a person act in a discretionary manner in devising school procedures, assigning tasks to other employees, and providing general supervision of employees. On the other hand, the court found the teacher was specifically assigned to bus duty and this job required performance of specific acts that were not discretionary in nature.
Respondeat Superior Liability: Non-Preemption Rule

Passenger, who is wheel-chair bound, was injured when she fell out of a malfunctioning chair lift on a public transportation bus. Several minutes passed before the bus driver, dispatcher, and supervisor called for assistance. The trial court found violations of company policy and found the bus company liable under respondeat superior for bus driver’s negligence, however, punitive damages were dismissed. The court of appeals granted passenger’s appeal seeking remanded for a trial on punitives, but denied the bus company’s seeking of reversal for improper admission of evidence of bus driver’s alleged alcoholism and mental health issues. The Supreme Court held the evidence of bus driver’s alcoholism was admissible for impeachment purposes and the bus company’s objection was not properly preserved for review; thus, there was no abuse of discretion. Next, as an area of first impression, under respondeat superior, the Supreme Court held the “non-preemption rule”, that a vicariously liable employer is not only liable for the injuries of the employee, but also liable for their own negligence in hiring the employee, is more consistent with Kentucky law and the Restatement (Second) of Agency §213 (1958) regarding the vicarious and actual liability of an employer. Lastly, the Supreme Court disagreed with the bus company’s assertion that a remand for trial solely on punitives violated the Kentucky law.

2. Appellate Court Decisions

a. Insurance Coverage Decisions


“Other Insurance” Provisions

Mother and son were injured by an uninsured motorist in an accident and sought uninsured motorist (UM) benefits from her son’s commercial and husband’s personal UM policies; each from different carriers. Both policies had “other insurance” provisions. The trial court applied the holding in Farm Bureau Ins. Co. v. Shelter Mut. Ins. Co., 326 S.W. 3d 803 (Ky. 2010) (disregarding apportionment and favoring the vehicle owner’s liability insurance as primary) holding UM coverage fell outside the scope of Kentucky’s MVRA and ordered damages to be pro-rated in concert with the common-law rule of mutual repugnance between the provisos. The appellate court held the unique nature of UM coverage in Kentucky, that it is not mandatory for an insured to carry, departs from Shelter's holding that the vehicle owner carries the primary. The court opined that primary coverage is maintained by the insured’s carrier since they, opting to choose UM coverage, control the risk and, therefore, the insured’s personal UM coverage was primary between the two carriers.
Choice of Law: Other Insurance; Priority of Coverage

Tortfeasor collided with insured who was driving a vehicle owned by his employer. Insured had insurance through his employer and through his Tennessee personal carrier. Insured filed a negligence claim and an uninsured motorist action against his employer’s insurer. The employer’s insurer filed a cross-claim against the insured’s personal insurer based on Kentucky’s pro rata law. The trial court granted summary judgment to insured’s personal insurer on claims against the employer’s insurer on the grounds that Tennessee choice of law controlled. In determining which state’s law is relevant, the appellate court referenced the Kentucky Supreme Court’s adoption of the “…most significant relationship to the transaction and the parties…” test of § 188(1) of the Restatement (Second) of Conflict of Laws (1971) and the factors of §6. State Farm Mut. Auto. Ins. Co., v. Hodgkiss-Warrick, 413 S.W.3d 875, 878 (Ky. 2013). Accordingly they held, the enumerated factors regarding the construction and application of insured’s personal insurer outweighed the arguments of the employer’s insurer, therefore, Tennessee law governs the choice of law. Further, per the Tennessee statute concerning priority of coverage, employer’s insurer was the primary insurer since the accident occurred while the insured was driving the employer’s vehicle. Finally, since the insured’s personal insurer’s policy provided no coverage for workers’ compensation payments under TCA § 56-7-1205, the appellate court held there was no obligation to pay any set-off to employer’s insurer.

Intentional Acts Provision

Insured shot and killed his brother-in-law. Administratrix sought declaratory judgment establishing insurer provided coverage. Insurer responded the insured’s intentional act did not constitute an occurrence and that bodily injury expected or intended was not covered. The trial court found the policy exclusion did not apply due to the ‘innocent co-insured’ provision and application of KRS 304.12-211(2)(b). Moreover, the decedent did not contribute to his own murder, and the loss arose under domestic violence, which was covered under the policy. Analyzing the statute, the appellate court focused on the language “the insurer shall not deny payment to an innocent co-insured … and the perpetrator of the loss is criminally prosecuted for the act[.]” The insured did not stand trial due to mental incompetency so it is unclear whether the intent component of the crime existed to characterize it as an intentional act. Even if it was intentional, the record was unclear whether the decedent was even an insured under the policy or whether the decedent’s death could be considered domestic violence. Since a genuine issue of material fact exists, the appellate court held summary judgment was not appropriate.
http://opinions.kycourts.net/coa/2012-CA-000477.pdf

Issue Preclusion; Escape Clauses

Insured filed two claims for damage to their home and personal property. One with their home insurer and, since the insured home was in foreclosure, a second on the policy the mortgagee obtained. Insurer made some payments, but stopped due to belief the damage was preexisting and discrepancies as to value and amount of personal property damage claimed. Insured filed an action against their home insurer and a third-party action against the mortgagee’s insurer. The jury found the insureds were not entitled to any more payments from the home insurer and they were not entitled to any proceeds from the mortgagee’s insurer due to issue preclusion. On appeal, the insureds argued mortgagee’s insurer was not entitled to judgment on the basis of issue preclusion and the insurer’s escape clause was void against public policy. The appellate court found since the lawsuits against home insurer and mortgagee’s insurer were identical, and the jury already made a finding on those issues, the action against mortgagee’s insurer was properly estopped. Regarding the escape clause, the court determined since the home insurer’s policy did not have an escape clause and provided coverage, the mortgagee’s insurer’s escape clause was invoked and valid.

b. UM/UIM Decisions

http://opinions.kycourts.net/coa/2013-CA-001439.pdf

UIM: “Regular Use”

Passenger wife of motorcycle owner was injured when she and her husband collided with an automobile. The motorcycle had undergone repairs and the husband had allowed coverage to lapse. Wife sought UIM coverage under their automobile policy. Their insurer denied the claim because the policy did not provide coverage for the motorcycle; further, the policy excluded coverage for bodily injury because the vehicle was owned by wife’s insured husband and it was available for his “regular use.” The trial court granted insurer’s motion for summary judgment based on the exclusions. On appeal, the wife argued “regular use” was not defined, therefore, they did not consider the motorcycle available to them for regular use because of the length of time it was being repaired, it was locked in storage at another residence and the test drive in which she was injured was special or occasional use. Insurer countered since the motorcycle was repaired two weeks before the accident it was available for regular use, the husband has a key for where it was stored and there was no requirement that the motorcycle actually had to be regularly used. The appellate court determined that the exclusion was triggered simply because the motorcycle was owned by wife’s husband and therefore, discussion of the “regular use” exclusion was unnecessary.

http://juryverdicts.net/HensleyvStateFarm.pdf

**UIM: Statute of Limitations**

Insured was injured in a motor vehicle accident while driving a vehicle owned by her employer. Tortfeasor’s liability carrier paid limits and insured gave a Coots notice for underinsured motorist coverage. Insurer denied the UIM claim as it was time-barred since the policy required the action be filed within two years of the accident. Insured responded the limitations period was unreasonable, inconsistent, and ambiguous, and should be construed in favor of the insured. Further, the statute of limitations should not begin to run until the date the carrier denied the claim. The trial court granted insurer’s motion for summary judgment reasoning that the policy provided insured with a reasonable amount of time to file suit. The appellate court agreed with the insured and held a breach of contract action for a UIM claim, being distinct from a tort-based claim of injury, begins when the insurer denies the insured’s claim, thereby breaching the contract. Since “accrues” is not defined in Kentucky’s Insurance Code, the appellate court determined “accrues” had a distinct meaning in 1970 when the General Assembly enacted KRS 304.14-370, that a statute of limitations “accrues” when the cause of action ripened under the law.

c. **No-Fault/PIP Decision**


http://opinions.kycourts.net/coa/2013-CA-000552.pdf

**Peer Review**

Chiropractic Board filed suit seeking injunctive relief against two physicians who performed peer reviews of a chiropractor’s treatment of an insured for personal injury protection (PIP) claims to an insurer. The trial court dismissed both actions. The physicians contended they have not conducted a peer review under KRS 312.200 subject to the Board’s censure; however, the Board argued they have conducted a peer review without the required licensure and training according to KRS 312.200(3) and were subject to injunction by the Board. “If a statute is reasonable susceptible to two constructions, one of which renders it unconstitutional, ‘the court must adopt the construction which sustains the constitutionality of the statute.’” *Davidson v. American Freightways, Inc.*, 25 S.W. 3d 94, 96 (Ky. 2000) (quoting *American Trucking Ass’n v. Commonwealth, Transp. Cabinet*, 676 S.W. 2d 785, 789-790 (Ky. 1984)). Relying on *Davidson*, the court held the Board’s interpretation would usurp the trial court’s authority to control evidence under KRE 702 by only allowing persons to testify to the reasonableness of the cost and necessity or chiropractic treatment if they have authorization by the Board. If the court accepted this theory, the statute would be unconstitutional. Moreover, the court reasoned since the physicians’ did not purport to conduct peer reviews under the Board’s specific KRS Chapter 312 process, the Board had no interest or authority over their activities. The court determined the Board had no authority to issue the injunctions and their interpretation of the statute would not be accepted by the court.
d. Other Significant Decisions

http://opinions.kycourts.net/coa/2013-CA-000812.pdf

Governmental Immunity

A student at a community college filed a negligence action when she stepped on glass partially hidden in grass on campus sustaining injury. The college requested dismissal based on governmental immunity. The student claimed the college’s purchase of liability insurance constituted a waiver of immunity. The trial court denied the college’s motion to dismiss. The appellate court overturned the decision holding the college, being funded by the treasury of the Commonwealth and subject to legislative directive, was immune from civil actions. Further, maintenance of the campus was integral to its operation and was not proprietary allowing for civil liability. Also, Kentucky case law has long held the purchase of liability insurance does not constitute a waiver of the college’s governmental immunity.

http://opinions.kycourts.net/coa/2012-CA-001642.pdf

Daubert Testimony

In a medical malpractice case the trial court allowed the doctor’s expert to testify a shot administered by a physician prior to surgery caused the injury at issue. On appeal, the injured patient asserted the trial court did not fulfill its gatekeeping function set out in Daubert, by failing to conduct a preliminary hearing to analyze the expert’s causation theory before introduction in the trial. The appellate court held a Daubert hearing is not required every time an expert’s testimony is offered per R.T. Vanderbilt Co., Inc., v. Franklin, 290 S.W.3d 654, 664-65 (Ky. Ct. App. 2009), and a hearing is not required if the record is sufficiently complete to measure the proffered testimony against the standards of reliability and relevance. Commonwealth v. Christie, 98 S.W. 3d 485 (Ky. 2002). The appellate court held the trial court conducted an adequate review by holding a preliminary hearing, allowing submission of briefs and reviewing the expert’s deposition testimony and found the opinion was based on his medical credentials, personal experience, warnings from product literature and other legitimate findings from medical professionals and was subject to “vigorous cross-examination.”

http://opinions.kycourts.net/coa/2013-CA-001549.pdf

Service of Process

Insurer sought subrogation claim against manufacturer of defective water heater. Manufacturer was registered with the Kentucky Secretary of State, but was headquartered in Pennsylvania. Insurer attempted service of summons four times, the last through the Kentucky Secretary of
State, each time it was returned undelivered. The trial court granted default judgment to insurer and manufacturer moved to set aside the verdict. The motion was denied and manufacturer appealed asserting excusable neglect warrants setting the default judgment aside. The court of appeal determined that manufacturer’s failure to receive actual notice was not because of the actions of the plaintiff, post office, or Secretary of State, rather because manufacturer, through willful ignorance or negligence, failed to maintain updated information regarding their corporate address or the proper agent to receive service.


Premises Liability: Motor Vehicle Accidents

Immediately upon termination from employment, employee was leaving the premises when he realized he forgot his lunchbox. He received permission from the guard to retrieve it and drove his motorized scooter across the parking lot where he sustained injuries to his person and scooter upon trying to avoid cable barriers. Employer contended the cable barrier was open and obvious and the trial court granted summary judgment to employer. On appeal, employee contends the holding of *Kentucky River Medical Center v. McIntosh*, 319 S.W.3d 385 (Ky. 2010) abolished the open and obvious doctrine and now requires a jury determination as to foreseeability of damages. The court referred to the clarifying opinion of *Shelton v. Kentucky Easter Seals Soc., Inc.*, 413 S.W.3d 901 (Ky. 2013), finding that the employer met their duty of care and no reasonable mind could conclude the employer should have anticipated their “brightly painted poles and cables” would have caused harm to an invitee.


Premises Liability: Post *Shelton* Duty of Care

Patron went to gas station and upon exiting the store slipped on ice and broke three ribs. Patron brought action against the gas station claiming as a business invitee the gas station owed him a duty to protect him from unreasonable risks and maintain the premises in a reasonably safe condition. The trial court granted gas station’s motion for summary judgment. Patron appealed contending the trial court erred in finding the ice was an open and obvious condition because patron’s injuries were foreseeable, which extended gas station’s duty to protect him and summary judgment was inappropriate because foreseeability is a factual determination to be made by a jury. The appellate court determined because patron was a business invitee, the gas station owed him the general duty of reasonable care, but also the specific duty associated with the land possessor-invitee duty of care. Further, the gas station was aware of the risk of physical harm extended to invitees and, therefore, a material fact existed as to whether gas station could have foreseen patron’s harm and whether it breached its duty to patron.
**Bullying: School Immunity and Duty of Care**

Parent of teenager filed a wrongful death action alleging negligence of school district after the teenager committed suicide as a result of bullying. The trial court granted the school district summary judgment based on the district’s entitlement to qualified official immunity and the teenager’s suicide was an intervening and superseding act the school district was not liable for. Parent appealed alleging the trial court erred to grant the school district immunity. The appellate court held qualified immunity is not afforded for “tort liability for the negligent performance of a ministerial act, i.e., one that requires only obedience to the orders, or when the officer’s duty is absolute, certain, and imperative.” The duties of the Superintendent were clearly ministerial as he was to develop procedures, such as investigation or reporting bullying complaints within a certain time frame, and the district staff was required to complete ministerial functions, such as resolving bullying complaints. Therefore, qualified immunity was improperly granted. However, there is no factual record showing the school district was aware the teenager was suicidal and the teenager committed suicide at his home, outside of the custodial duty owed by the school. Therefore, the parent’s cause of action was properly dismissed for lack of causation since the suicide was a superseding cause outside of the school’s duty of care.

**Revival of Claim Upon Death**

An injured party filed a personal injury action against the insured-tortfeasor after a motor vehicle accident. While litigation was pending, the insured died and his insurer did not become aware of this until over a year later. The insurer advised the injured party’s counsel of the death and asserted the action was barred by KRS 935.278 as an application to revive the claim had not been made within one year of the death. The injured party filed a motion to revive the action and amend the complaint to include violations of the Unfair Claims Settlement Practices Act and Kentucky’s Consumer Protection Act. The trial court granted the insurer carriers motion to dismiss according to KRS 395.278. The appellate court agreed and held the one-year provision to amend an action after the defendant died is a statute of limitations and not open to extension. The injured party asserted emails between counsel for the parties, after the insured’s death, constituted tolling the one-year period because the insurer’s actions in failing to advise of the death were affirmative acts intended to deceive. However, the court found tolling was inappropriate because the insurer had no knowledge of the insured’s death, thus intending to deceive was factually impossible.
**Bad Faith**

Following a motor vehicle collision, the injured party sued the tortfeasor’s insurer for third-party and statutory bad faith for failing to reasonably evaluate, investigate, and negotiate a settlement of her bodily injury claim. Insurer moved for summary judgment on the grounds it did not act in bad faith because it had the right to insist that the injured party prove her case before settling her claim. The injured party argued by paying the property damage claim and settling the bodily injury claim, the insurer admitted their insured’s liability; thus the delay in settlement of her bodily injury claim was evidence of bad faith. The trial court found there was a genuine dispute as to the liability of the accident and causation of injuries, therefore, summary judgment was granted to the insurer. The appellate court determined the two primary sources of evidence injured party presented are not, in fact, considered evidence. The injured party did not sign and swear to her interrogatory answers and her expert report was not correctly characterized as an affidavit. Further, the elements in *Wittmer v. Jones*, 864 S.W.2d 885 (Ky. 1993) only apply when liability for paying the underlying claim is “beyond dispute.” *Coomer v. Phelps*, 172 S.W.3d 389, 395 (Ky. 2005); otherwise, an insurer has a right to defend the case until appellate review is final. Since the damaged vehicle owner failed to prove beyond dispute tortfeasor was liable for the accident, it was reasonable for insurer to rely on their insured’s version of events; accordingly, there was nothing in the record to indicate insurer’s bad faith.

**Choice of Law**

Insured was named in a class action lawsuit regarding his business practices. Pursuant to their professional liability policy, the insured requested the insurer defend and indemnify him against the lawsuit. After a year, the insurer refused to defend and indemnify citing no contractual obligation to do so. The insured filed a motion for declaratory judgment against the insurance company. Applying Ohio law to interpretation of the insurance contract, the trial court found exclusionary language in the policy did not require the insurer defend and indemnify the insured. On appeal, the insured argued Kentucky law applied to the interpretation of the policy since the class action and associated actions occurred in Kentucky. The insurer argued Ohio law controlled since the policy for insurance was entered into in Ohio. The appellate court concluded that choice of law is a factual finding determined by “which state has the most significant relationship to the transaction and parties.” *Lewis v. American Family Ins. Group*, 555 S.W. 2d 579 (Ky. 1977). Accordingly, the case was remanded for proceedings to determine which law controls.
Premises Liability: Invitee vs. Licensee

Neighbor became injured when she fell while returning a baking pan to homeowner’s porch. Neighbor filed negligence action against homeowner’s estate (now deceased). After discovery, the trial court granted the Estate’s motion for summary judgment because neighbor had not established the porch was a substantial factor in causing the injuries. Neighbor appealed arguing the open and obvious condition of the porch is no longer a bar to recovery under the modified analysis of Shelton v. Kentucky Easter Seals, Soc., Inc., 413 S.W.3d 901 (Ky. 2013). However, the appellate court distinguished the duty to an invitee is different to a licensee, and all parties agreed the neighbor was a licensee. The duties owed under Shelton and Kentucky River Medical Center v. McIntosh, 319 S.W.3d 385 (Ky. 2010) are only factors in determining whether the premises owner satisfied their duty of care. Since the neighbor failed to show proof of causation, observation of defects in the porch, provide expert testimony as to a defect, or explain why she fell, summary judgment was proper.

Bad Faith/UCSPA

Insured, a father driving his two sons, was involved in a motor vehicle accident in which the tortfeasor caused a head on collision. The father and one son were severely injured; the other son died as a result of his injuries. Estate of the deceased son filed common law and statutory bad faith claims against insurer after they failed to pay nineteen months after the claim. The trial court granted summary judgment to insurer, opining the conduct of insurer did not rise to harassment or deception and there was no proof insurer’s delay in payment was to extort a more favorable settlement. On appeal, the court held questions of fact remained as the Estate provided an expert who opined the insurer’s actions were in bad faith under the common law and the expert’s found the insurer’s actions may have been intentional or reckless-required for violations under the UCSPA. Therefore, summary judgment on both issues was improper.

Reservation of Rights

A condominium association brought common law and statutory bad faith actions against the condominium builder’s insurer after the insurer’s legal counsel denied the association’s claims relating to damage and faulty construction of the buildings. The trial court granted the association’s motion enjoining the insurer from asserting coverage defenses since the insurer failed to issue a Reservation of Rights letter until two years after notice of the association’s claims. On appeal, the insurer contended the trial court erred in failing to apply the holding of Cincinnati Ins. Co. v. Motorist Mut. Ins. Co., 306 S.W. 3d 69 (Ky. 2010), which changed the law
holding coverage in a CGL policy is not triggered by “mere faulty workmanship” and failure to apply this holding created and/or enlarged the scope of their insurance coverage in violation of Kentucky law. The association cited the Kentucky Supreme Court’s reference to \textit{Hood} in the \textit{Cincinnati} decision that a failure to issue to Reservation of Rights by an insurer acts as waiver or estoppel of coverage as a defense, even if it expands the coverage. Additionally, even if the insurer does not anticipate the need for a Reservation of Rights, this burden lies only with the insurer, not the insured or a third party in the insured’s shoes, therefore estoppel was proper.

\textcolor{blue}{http://opinions.kycourts.net/coa/2013-CA-000192.pdf}

Bad Faith: Expired Policy

A homeowner alleged blasting from a construction company caused damage to her home. The homeowner filed suit against the construction company’s insurer alleging a violation of Kentucky’s Unfair Claim Settlement Practices Act (UCSPA) as their attorneys failed to respond to correspondence from her attorney. The trial court found the insurer’s policy with the construction company ended approximately seven months prior to when the damage was incurred. Under KRS 304.12-230(2), a bad faith claim under the UCSPA can only be brought in relation to occurrences “arising under insurance policies.” Since the only material fact was that insurer did not have a policy at the time of homeowner’s damage, a claim against the insurer could not be sustained.

\textcolor{blue}{http://opinions.kycourts.net/coa/2011-CA-000223.pdf}

Premises Liability: Post Shelton

Patron sustained injuries upon falling into an eroded area of the parking lot pavement of gas station. At the bench trial, the trial court found that the eroded area was an unreasonably dangerous condition. On appeal, the gas station contended the trial court erred by not applying the open and obvious doctrine and failed to consider the comparative fault of the patron. The appellate court concluded the evidence of the dangerous condition of the eroded area showed it was well-lit and obvious to a person of normal prudence; thus, the applicable standard to apply was that of \textit{Shelton v. Kentucky Easter Seals Soc., Inc.}, 413 S.W.3d 901 (Ky. 2013). In accord with \textit{Shelton}, the court found that a small pothole in the parking lot did not create an unreasonable risk of harm.
Premises Liability: Duty to Repair Open and Obvious Hazards

Tenant brought action against landlord after tripping in a gap between the porch and tenant’s leased mobile home. Tenants previously informed the landlord of the hazard and it became worse over time. The trial court found the hazard was open and obvious and the landlord had no duty to protect from known hazards. On appeal, tenant argued the standard adopted by the Kentucky Supreme Court in *Kentucky River Medical Center v. McIntosh*, 319 S.W.3d 385 (Ky. 2010) was controlling since an open and obvious condition was no longer a bar to recovery. The appellate court held the trial court was correct in distinguishing the duties set forth in *McIntosh* of land possessor and invitee from those in this case of landlord and tenant. Absent latent or unknown defects, a tenant takes the premises as he finds them, and the landlord is not liable for injuries sustained from a known defective condition and *McIntosh* was not applicable.

3. Federal Court Decision

http://www.ca6.uscourts.gov/opinions.pdf/14a0400n-06.pdf

Duty to Defend; Duty to Indemnify

Insured, a racetrack, brought breach of contract and bad faith action against its insurer for wrongfully declining to defend or indemnify insured from a wrongful death suit after a patron consumed too many alcoholic beverages and was involved in a motor vehicle accident in which a passenger died. Insurer argued they had neither a duty to defend or indemnify pursuant to the CGL policy’s “liquor liability exclusion.” On summary judgment, the court found insurer’s failure to defend or indemnify constituted a breach of contract, but it was not done so in bad faith. Insurer appealed the breach of contract decision and insured cross-appealed the bad faith decision. The insurer contended the policy excluded liability coverage arising out of the sale of alcohol if the insured was in the business of “manufacturing, distributing, selling, serving or furnishing alcoholic beverages.” The Sixth Circuit agreed, citing the concession agreement and the rights and responsibilities of the contractor and subcontractor utilized for concessions. The court determined the insurer had no duty to defend because that decision is made at the outset of litigation based on the complaint and the known facts and allegations established the insured was in the business of selling alcohol in violation of the “liquor liability exclusion.” Regarding the duty to indemnify, the court held the duty only existed for liability covered by the contract. Since the insurer was not obliged by either a duty to defend or indemnify, they did not act in bad faith.
D. **Significant Cases Pending Before the Kentucky Supreme Court**


**Automobile Insurance: Employee Exclusion**

The issue on appeal is whether the severability-of-interests clause in a business auto liability policy defeats the policy's employee exclusion when the insured is not the policyholder, but a permissive user.


**Coverage: "Notice of First Renewal"**

The issue on appeal is whether the insured adequately complied with KRS 304.20-040(14) "notice of first renewal" requirement of a “notice stating in substance that added UM, UIM, and PIP coverage may be purchased by the insured" despite the fact the insured never requested nor paid for underinsured motorist coverage.

*State Farm v. Riggs*, 2013-SC-618-DG

**Coverage: UIM Statute of Limitations**

The issue on appeal concerns whether an insurance policy provision requiring underinsured motorist claims to be brought the same time as tort claims under the MVRA is valid and enforceable.


**MVRA: Statute of Limitations**

The issue on appeal addresses whether the statute of limitations on basic reparations benefits begins to run from the date the last check for benefits is paid, even if it is a replacement check, or if the statute begins to run from the date the initial last payments were made.

*State Farm v. Hensley*, 2014-SC-000551-DG

**Coverage: UIM Statute of Limitations**

The issue on appeal is whether the statute of limitations on a underinsured motorist claim begins to run on the date of the accident or on the date the insurance carrier denied the underinsured motorist claim and conveyed that to the insured.
Countryway Insurance Company v. United Financial Casualty Company and Sharon Bartley, 2014-SC-000265-DG

Other Insurance Provisions

The issue on appeal is which insurance policy is the primary policy for purposes of underinsured motorist coverage when each contains an “other insurance” clause: the injured party’s personal insurer or the insurer of the vehicle involved in the accident.

These cases were pending at the time this summary was printed. To confirm whether the Supreme Court has issued a decision in any of these cases, we invite you to visit our website at http://www.smithrolfes.com.

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V.  **THE STATE OF INDIANA**

A.  **FREQUENTLY CITED INDIANA STATUTES**

1.  **Automobile Insurance**

   I.C. § 9-25-2-3  
   Financial Responsibility  
   Requires insurance in the following amounts:
   
   (1)  $25,000.00 per person;
   
   (2)  $50,000.00 per accident; and
   
   (3)  $10,000.00 property coverage per accident.

   I.C. § 27-7-5-2(a)  
   UM/UIM Coverage  
   Requires insurers to offer UM/UIM coverage with every bodily injury liability policy of insurance in an amount not less than $50,000.00 or the limit of liability insurance, whichever is greater and which can only be rejected in writing.

   I.C. § 27-7-5-4(a)  
   Uninsured Motor Vehicles  
   An uninsured motor vehicle is one without liability insurance or not otherwise compliant with the financial responsibility requirements of such laws of this or another state or where the insurer is unable to make payments to the limit of liability due to insolvency.

   I.C. § 27-7-5-4(b)  
   Underinsured Motor Vehicles  
   An underinsured motor vehicle is one where the limits of coverage available for payment to the insured under all bodily injury liability policies covering persons liable to the insured are less than the limits of the insured’s underinsured motorist coverage.

   I.C. § 27-7-6-2  
   Definitions  
   This statute contains the definitions for “automobile insurance policy”, and “automobile liability coverage”.

2.  **Negligence, Other Torts and Contribution**

   I.C. § 7.1-5-10-15.5  
   Civil Liability for Furnishing Alcohol  
   A person who furnishes alcohol is not liable for civil action for damages caused by the intoxicated person, unless they actually knew the person was visibly intoxicated, and the intoxication of the person was the proximate cause of the injury or damage.
If a person, who is 21, suffers an injury or death, caused by voluntary intoxication, the person, the person’s heirs, dependents or representative may not make a claim against the person who furnished the alcohol.

I.C. § 12-15-29-4.5
Medicaid Claim

Insurer must accept a Medicaid claim for a Medicaid recipient for three (3) years from the date of service. An insurer cannot deny a Medicaid claim solely based on the date of submission, type or format of the claim, method of submission or failure to provide proper documentation.

Insurer cannot deny a Medicaid claim solely due to lack of prior authorization. Insurer will conduct the prior authorization retrospectively when prior authorization is necessary. Insurer must adjudicate such claim as if it received prior authorization.

I.C. § 14-22-10-2.5
Entry Onto Premises of Another

A person, who enters a premise, without permission or monetary compensation, for the purposes of hunting or fishing, does not have an assurance that the premise is safe.

The owner of a premise does not assume responsibility or incur liability for damage or injury caused by others persons using the premises.

I.C. § 22-3-10-1
Ban on Employer Waiver of Liability

Any contracts between an employer and an employee, or any contracts between an employee and any third-party, which purport to release the employer or third-party from any liability for damages arising out of the negligence of the employer or third-party are against public policy and declared null and void.

I.C. § 34-18-8-4
Medical Malpractice – Prerequisite to Commencement of Action

Prior to commencing a medical malpractice action in Indiana, the claimant’s proposed complaint must be presented to a “medical review panel” for review, and the panel must provide an opinion regarding whether or not the evidence supports the alleged conclusions.

I.C. § 34-20-1-1
Products Liability Actions

The article governs all actions that are brought by a user or consumer against a manufacturer or seller for physical harm caused by a product regardless of the substantive legal theory or theories upon which the action is brought.

I.C. § 34-20-2-1
Product Liability

Liability exists for an unreasonably dangerous or defective product if the seller should reasonably foresee the consumer or class of persons being exposed to the harm caused by the defective condition, the seller is engaged in the business of selling the product and the product reaches the user or consumer without substantial alteration.
I.C. § 34-20-2-2
Product Liability
An action can be maintained even though reasonable care was used in the manufacture and preparation of the product and there is no privity of contract. However, reasonable care is a defense to design defect claims and those for failure to provide adequate warnings.

I.C. § 34-20-2-3
Strict Product Liability
An action for strict product liability for an unreasonably dangerous defective condition may only be brought against the manufacturer.

I.C. § 34-20-2-4
Product Manufacturers
If a court cannot gain jurisdiction over a manufacturer, then the manufacturer’s principal distributor or seller over whom the court can gain jurisdiction will be deemed the manufacturer of the product.

I.C. § 34-20-3-1
Product Liability
A product liability action in negligence or strict liability must be commenced within two (2) years from the cause of action or within ten (10) years after the delivery to the initial user or customer. If the cause of action happens after eight (8) years but before ten (10) years of the date of delivery, the action may be commenced within two (2) years after the cause of action.

I.C. § 34-20-9-1
Indemnity in Product Liability Actions
A party held liable may seek indemnity from other persons whose actual fault caused the product to be defective.

I.C. § 34-23-1-1
Wrongful Death
Requires an action in wrongful death to be maintained by the personal representative of the decedent and to have been able to have been prosecuted by the decedent had the decedent lived.

I.C. § 34-23-1-2(d)
Limitation of Certain Wrongful Death Damages
The type of damages in subsection (c)(3)(A) (reasonable medical, hospital, funeral and burial expenses) are limited to $300,000.00.

I.C. § 34-31-4-1
Parental Liability
A parent is liable for no more than $5,000.00 in actual damages from damage caused by their child, if the parent has custody and the child is living with the parent.
I.C. § 34-44-1-3  
Payments of Awards  
Proof of payments may be considered by trier of fact for determining the amount of any award and for any court review of awards considered excessive.

I.C. § 34-51-2-2  
Comparative Fault of Governmental Subdivisions  
Contributory negligence remains a complete defense to claims under the Tort Claims Act.

I.C. § 34-51-2-5  
Comparative Fault Set-Off  
Contributory fault of a claimant acts to proportionately reduce the total damages for an injury by the claimant’s contributory fault.

I.C. § 34-51-2-6  
Contributory Negligence as Complete Defense  
Contributory negligence is a complete defense if a claimant’s contributory fault is greater than the fault of all other persons whose fault proximately contributed to the claimant’s damages.

I.C. § 34-51-2-10  
Intentional Torts  
A plaintiff may recover one-hundred percent of the compensatory damages in a civil action for an intentional tort from a defendant who was convicted after a prosecution based on the same evidence.

I.C. § 34-51-2-12  
Contribution and Indemnity  
In an action under this chapter, there is no right of contribution among tortfeasors. The right of indemnity is unaffected by this section.

I.C. § 34-51-2-14  
Nonparty Defense  
In an action based on fault, a defendant may assert that the damages of the claimant were caused in full or in part by a nonparty.

I.C. § 34-51-2-15  
Nonparty Defense  
The burden of proving a nonparty defense is upon the defendant who must affirmatively plead the defense.

I.C. § 34-51-2-16  
Nonparty Defense  
A nonparty defense must be pled if known. Nonparty defenses which become known after the filing of the answer must be raised with reasonable promptness. If the summons and complaint were served more than one hundred fifty (150) days prior to the expiration of the claimant’s statute of limitations, nonparty defenses must be pled no later than forty-five (45) days prior to
the expiration of that limitation of action; however, the trial court may alter these time limits to allow defendants a reasonable opportunity to discover the existence of a nonparty defense and allow the claimant a reasonable opportunity to add the nonparty as an additional defendant prior to the expiration of the period of limitations applicable to the claim.

I.C. § 34-51-3-2
Punitive Damages – Clear and Convincing Evidence

Any claim for punitive damages must be established by clear and convincing evidence to support an award.

I.C. § 34-51-3-4
Punitive Damages – Maximum Award

Any punitive damage award may not be more than the greater of:

1. Three times the amount of compensatory damages; or
2. Fifty Thousand Dollars ($50,000.00).

I.C. § 34-51-3-5
Punitive Damages – Mandatory Reduction

If a trier of fact awards punitive damages that exceed the maximum allowable award, the court shall reduce the punitive damage award to an amount no more than the greater of:

1. Three times the amount of compensatory damages; or
2. Fifty Thousand Dollars ($50,000.00).

3. Subrogation

I.C. § 27-7-5-6(a)
Subrogation for UM/UIM Payments

Provides that payment of UM/UIM coverage for damages operates to subrogate the insurer to any cause of action in tort which payee may have.

I.C. § 27-7-5-6(b)
Exception to the Right of Subrogation for UIM Payments

The insurer providing underinsured motorist coverage does not have the right of subrogation if it is informed of a bona fide offer of settlement which includes a certification of the liability coverage limits of the underinsured motorist and the insurer fails to advance payment in at least the amount of the offer within thirty (30) days.

I.C. § 34-51-2-19
Lien Reduction

Subrogation claims or other liens or claims arising out of the payment of medical expenses or other benefits as the result of personal injuries or death shall be diminished by the claimant’s comparative fault or the un-collectability of the full value of the claim resulting from limited liability insurance or any other cause in the same proportion as the claimant’s recovery is
reduced. The lien or claim shall also bear a *pro rata* share of the claimant’s attorney fees and litigation expenses.

4. **Insurance Fraud**

**I.C. § 27-2-13-2**

**Release of Information by Insurer**

Insurer must furnish policy information relevant to fire loss, history of claims of claimant, and materials relating to fire investigation, if requested by an authorized agency investigating a fire loss.

**I.C. § 27-2-13-3**

**Arson Reporting**

When an insurer has reason to believe a fire loss in which it has an interest is caused by a means that was not accidental, then the company shall notify an authorized agency in writing and provide that agency with all materials developed from the insurer’s investigation of the fire loss. The insurer shall also provide the office of the State Fire Marshal a copy of any information provided under this section.

**I.C. § 27-2-13-4**

**Arson Reporting**

When an authorized agency receives information under this chapter, it may release or provide the same information to any other authorized agency to further its investigation. In addition, an insurer who provides information under this chapter has the reciprocal right to request and receive relevant information from that agency. Finally, an insurer or authorized agency, who releases or provides evidence or information under this chapter, is immune from any civil or criminal liability for providing the evidence or information.

**I.C. § 27-2-13-5**

**Arson Reporting**

When an authorized agency is investigating a fire that it believes to have been caused by arson it may, in writing, order an insurer to withhold payment of any policy proceeds on the damaged or destroyed property for up to thirty (30) days from the date of the order. The insurer may not make a payment during that time, except as follows:

1. Emergency living expenses;
2. Emergency action necessary to secure the premises;
3. To prevent further damage to the premises; or
4. To a mortgagee who is not the target of the investigation of the authorized agency.

**I.C. § 27-2-14-2**

**Vehicle Theft Reporting**

If an insurer has reason to believe that a vehicle theft claim made by an insured is fraudulent, the insurer shall notify, in writing, an authorized agency of the suspected fraudulent claim and provide the agency with all materials developed from the insurer’s investigation.
Vehicle Theft Reporting

An authorized agency investigating a vehicle theft may, in writing, require an insurer investigating the loss to release any and all relevant information or evidence considered important to the authorized agency, including:

1. Pertinent policy information (including a policy application);
2. Policy premium payment records;
3. History of prior claims made by the insured; and
4. Material relating to the investigation, including:
   a) Statements;
   b) Proofs of Loss; and/or
   c) Other relevant evidence.

Vehicle Theft Reporting

An authorized agency provided with information under this chapter may release or provide the same information to any other authorized agency to further its investigation. In addition, an insurer who provides information under this section has the reciprocal right to request and receive relevant information from that agency. When requested, the agency shall provide the requested information within a reasonable time, not exceeding thirty (30) days. Finally, an insurer or authorized agency that releases or provides evidence or other information under this chapter is immune from civil or criminal liability for providing that information.

Claim Forms

All preprinted claim forms required by an insurer as a condition of payment of a claim must contain a statement which clearly states the following: “A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.”

Immunity for Exchange of Information

An insurer, attorney, or investigative agency that receives and provides information pursuant to the requirements of the Indiana Code in good faith is immune from liability arising from the act of receiving, or the act of providing the information.

Fire Investigation

A fire department must investigate and determine the cause of fire in their territory. If the fire chief believes a crime was committed, he must notify the division and submit a report. The report must include: (1) a statement of facts; (2) the extent of damage; (3) the amount of insurance; and (4) other information required in the commission’s rules. To carry out this section, the fire department may: (1) enter and inspect property; (2) cooperate with prosecuting attorney;
(3) subpoena witnesses and documents; (4) give oaths; (5) take depositions and conduct hearings; and (6) separate witnesses and regulate the course of proceedings.

5. **Miscellaneous Statutes**

**I.C. § 22-3-2-6**

**Workers’ Compensation – Exclusive Remedy**

The Indiana Workers’ Compensation Administration provides the exclusive rights and remedies granted to an employee by account of personal injury or death, by accident, while that employee is within the course and scope of his employment.

**I.C. § 25-10-1-15**

**Admissibility of Chiropractor Testimony**

A chiropractor’s testimony relating to records or reports of a licensed medical physician may be admissible as evidence at trial if:

1. The chiropractor is properly qualified as an expert; and
2. The court is satisfied the information which the chiropractor testifies about is of the type reasonably relied on by other chiropractors.

**I.C. § 27-4-1-4.5**

**Unfair Claim Settlement Practices**

The statute sets forth certain actions/inactions which may constitute unfair claim settlement practices under Indiana law.

**I.C. § 34-14-1-1**

**Declaratory Judgment**

A court may declare rights, status, and other legal relations whether or not further relief is or could be claimed.

**I.C. § 34-14-1-2**

**Declaratory Judgment**

A person interested under a deed, will, written contract, or other writings or whose rights, status, or other legal relations are affected by a statute, municipal ordinance, contract, or franchise may have questions of construction or validity determined or obtain a declaration of rights, status, or legal relations thereunder.

**I.C. § 34-50-1-4**

**Qualified Settlement Offer**

This is essentially a codification of the Trial Rule 68 Offer of Judgment. When a qualified settlement offer is made pursuant to this statute, and not accepted, then the party rejecting the offer must ultimately obtain a more favorable judgment. If the rejecting party fails to obtain a more favorable judgment, the offering party is entitled to attorney’s fees, costs, and expenses in an amount not to exceed $1,000.00. To be valid, a qualified settlement offer must:

1. Be in writing;
(2) Be signed by the offeror or the offeror’s attorney;
(3) Be designated on its face as “qualified settlement offer;”
(4) Be delivered to each recipient or the recipient’s attorney by:
   a) Registered or certified mail; or
   b) Any other method that verifies the date of receipt; and
(5) Set forth the complete terms of the settlement proposal in sufficient detail to allow
    the recipient to decide whether to accept or reject it;
(6) Include the name and address of the offeror and the offeror’s attorney; and
(7) Expressly revoke all prior qualified settlement offers made by the offeror to the
    recipient.

I.C. § 34-51-4-8
Prejudgment Interest

If a court awards prejudgment interest, the court must determine the period during which
prejudgment interest accrues, which may not exceed 48 months. Generally, prejudgment interest
will begin to accrue on the latest of the following dates:

(1) Fifteen months after the cause of action accrued; and
(2) Six months after a medical malpractice claim is filed (if, I.C. § 34-18-8 and
    I.C. § 34-19-9 do not apply) or one hundred eighty (180) days after a medical
    review panel is formed to review a medical malpractice complaint.
(3) In all cases, however, the court shall exclude any period of delay that the court
determines is caused by the party requesting prejudgment interest.
### B. **Indiana Statutes of Limitations**

<table>
<thead>
<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Except those based upon a written contract, within two years of the date of the act or omission complained of.</td>
</tr>
<tr>
<td>I.C. § 34-11-2-1</td>
<td></td>
</tr>
<tr>
<td>Medical Malpractice</td>
<td>Within two years from the date of the act, omission or neglect complained of.</td>
</tr>
<tr>
<td>I.C. § 34-11-2-3</td>
<td></td>
</tr>
<tr>
<td>Personal Injury, Injury to Character and Injury to Property</td>
<td>Within two years after the cause of action arises.</td>
</tr>
<tr>
<td>I.C. § 34-11-2-4(2)</td>
<td></td>
</tr>
<tr>
<td>Product Liability</td>
<td>Within two years after the cause of action accrues; or not more than ten years after the delivery of the product to the initial user or consumer. However, if the cause of action accrues at least eight years but less than ten years after that initial delivery, the action may be commenced at any time within two years after the cause of action accrues.</td>
</tr>
<tr>
<td>I.C. § 34-20-3-1(b)</td>
<td></td>
</tr>
<tr>
<td>Wrongful Death</td>
<td>Within two years after the death of the decedent.</td>
</tr>
<tr>
<td>I.C. § 34-23-1-1</td>
<td></td>
</tr>
<tr>
<td>Bad Faith</td>
<td>Two years from alleged act of bad faith.</td>
</tr>
<tr>
<td>I.C. § 34-11-2-4(2)</td>
<td></td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td>Within two years from the date the cause of action accrues.</td>
</tr>
<tr>
<td>I.C. § 22-3-9-8</td>
<td></td>
</tr>
</tbody>
</table>
C. SIGNIFICANT INDIANA COURT DECISIONS

1. Supreme Court Decisions

   a. Insurance Coverage Decisions

   http://www.in.gov/judiciary/opinions/pdf/03131401mm.pdf

   UIM Policy Setoff Provision Unenforceable

   Plaintiff, a bus driver, was injured in a collision with an underinsured motorist (UIM). He received $71,958.80 from worker’s compensation and $25,000.00 from the tortfeasor’s liability insurer. The plaintiff’s personal insurance policy included $50,000.00 in UIM coverage. Plaintiff filed a UIM claim for $25,000, the difference between his UIM limit and the tortfeasor’s policy limit. The defendant insurer denied the UIM claim, because the policy stated when another legally liable party makes payments, those payments reduce the insurer’s liability. Because worker’s compensation had paid more than the policy’s UIM limit, the insurer argued that its liability was $0. The Supreme Court disagreed. The court held that the policy provision was in violation of Indiana’s UM/UIM statute. The statute requires insurers to provide coverage of not less than $50,000.00. Because the plaintiff did not receive the minimum guaranteed by statute, he was still entitled to $25,000.00 from his insurer. The court also held that any similar policy provision is unlawful and unenforceable.


   Statute of Limitations for Negligent Procurement of Coverage

   Plaintiff insured claimed the defendant’s agent negligently failed to obtain a 100% replacement cost dwelling policy. The Supreme Court concluded that the cause of action for the plaintiff’s claim was barred due to the statute of limitation expiring. The plaintiff failed to discover that the policy expressly limited the dwelling loss replacement, and this failure barred the plaintiff’s claim against the agent. Ultimately, the court held that the statute of limitations for a claim for the negligent procurement of coverage begins at the onset of the policy if the breach was discoverable by the insured through ordinary diligence.

   http://www.in.gov/judiciary/opinions/pdf/05281402bd.pdf

   Wrongful Death: Assumed-Duty and Vicarious Liability

   Plaintiffs brought a wrongful death action against defendant national fraternity after the death of their eighteen year old son, a freshman pledge of the local fraternity, from acute alcohol ingestion. The trial court granted defendant’s motion for summary judgment, and the appellate
court affirmed. Plaintiffs contended that defendant was liable under an assumed-duty and/or vicarious liability theory. The court held that defendant was not liable under an assumed-duty theory, finding that the defendant did not have day-to-day oversight and control over the activities of the local fraternity and its members. The court also held that defendant was not liable under a vicarious liability theory, finding that an agency relationship did not exist between the defendant and the local fraternity or its members.

*Asklar v. Gibb, 9 N.E.3d 165 (Indiana 2014)*
http://www.in.gov/judiciary/opinions/pdf/05291401mm.pdf

**Rejection of UIM Coverage**

Plaintiff, driver of a semi-tractor trailer, was injured by a second semi-tractor trailer in West Virginia. Believing his damages would exceed the other driver’s liability policy, plaintiff joined his truck lessor’s insurer to determine the limit of UIM coverage available. Insurer asserted that it provided $5,000,000.00 in liability coverage for the insured’s semi-tractor trailer, but that the policy included only $75,000.00 in UIM coverage based on the insured’s signed waiver forms. In granting the insurer’s motion for summary judgment, the trial court applied Georgia law, which allows an insured to decide to purchase UIM coverage in an amount less than the liability policy limit. The trial court found that there was sufficient evidence to show that the truck owner-lessee had selected the $75,000.00 in UIM coverage. The insured appealed, asserting that Indiana law applied, which requires an explicit written rejection of UIM coverage below the policy limit. The Supreme Court found that Indiana law applied, and reversed the granting of summary judgment. The court observed the policy Declarations page listed the UIM coverage at $75,000.00, but the written waiver forms did not identify the policy by number and only mentioned the limits of “uninsured” not “underinsured” coverage, and were insufficient as a matter of law to grant insured’s motion for summary judgment.

**b. Other Significant Decision**

*F.D. v. Indiana Department of Child Services, 1 N.E.3d 131 (Ind. 2013)*

**Limitation on Sovereign Immunity**

Plaintiffs alleged mishandling of child abuse reports by the Indiana Department of Child Services (DCS), the Evansville Police Department (EPD), and the Vanderburgh County Prosecutor’s Office (VCPO). In the lower court, summary judgment was granted on all counts against all defendants on grounds of immunity. Plaintiff appealed the grant in favor of DCS and EPD, not VCPO. The court held that summary judgment was proper for EPD, but it was not proper for DCS because the parents claimed that its inaction hindered their ability to obtain proper treatment.
2. Appellate Court Decisions

a. Insurance Coverage Decisions


**UIM Benefits and Worker’s Compensation**

Insured driver sued auto insurer to recover UIM benefits. Insured had already received worker’s compensation benefits and payment from the tortfeasor’s insurer. The court held that it was not an error for the trial court to reduce the amount the insured received from worker’s compensation from the policy limit. The court also held that the insured may have been entitled to receive the remaining UIM amount, depending upon the insured total damages. Because the court wanted to preserve the purpose of the statute and allow for the possibility that the insured could have been entitled to more, the court remanded on the latter issue.


**Intentional Acts Exclusion**

A fire, caused by plaintiff’s wife, burned down his residence. Defendant denied his claim under the intentional acts exclusion. Plaintiff asserted that 1) his homeowners policy was not clear and unambiguous, and 2) that plaintiff was an innocent co-insured spouse protected from the intentional act of his wife setting the house ablaze. The lower court granted defendant’s summary judgment motion and that decision was upheld on appeal. The appellate court held the policy was not ambiguous and, regardless of his innocence, the intentional acts provision allowed his insurer to deny plaintiff’s claim.


**Bad Faith Litigation**

Defendant insurer appealed the judgment of the trial court, which awarded plaintiff insured attorney’s fees based upon the fact that insurer did not disclose information it discovered approximately one week before trial. Insurer discovered on the internet that insured husband’s medical license had come under investigation for prescriptions that he forged for his wife/insured, and used this information during its cross-examination of insured’s husband. The insurer researched the scope of its duty to disclose the information before deciding not to disclose. The appellate court held that the insurer was not under a duty to disclose, and did not litigate in bad faith.
**Known Claim Exclusion**

The plaintiff purchased insurance from the defendant for coverage of land that was contaminated. The plaintiff found out the land was contaminated, at the latest, right after purchasing the initial policy for a four year period. The court applied the “known claim” exclusion and not the “known loss” exclusion and found that the knowledge barred the years two through four of coverage. Under the language of the policy, the court must first determine whether the general coverage clause or exceptions would exclude coverage. The “known claim” exclusion bars coverage after the date the deficiency is first known, regardless of whether or not prior knowledge is found. If prior knowledge is found then it only applies to the first year of coverage, as under the “known loss” exclusion.


**Hit-and-Run Coverage**

Plaintiffs appealed a grant of summary judgment for the defendant insurance company, which denied plaintiffs’ claim for uninsured motorist coverage after a hit-and-run accident. Since the driver who caused the accident fled the scene, there was no available bodily injury liability insurance policy. This brought the hit-and-run motorist within the first of the three uninsured motor vehicle definitions in the policy. Thus, the court reversed and held that as a matter of law the car that hit plaintiffs was uninsured and coverage must be provided.


http://www.in.gov/judiciary/opinions/pdf/11141302nhv.pdf

**Contractual Ambiguity**

Plaintiffs were injured in a car accident where the other driver was at fault. After settling with the tortfeasor for the limit of her liability insurance, plaintiffs sued their own insurance company for damages under the UIM coverage. Defendant argued that the claim was contractually barred because the suit was not filed within two years of the accident. Plaintiffs argued the policy was ambiguous because it required the insured to either settle or obtain a judgment against the tortfeasor before suing the insurer. The court held that the disputed provisions, when read together, made it unclear when plaintiffs should have filed suit to preserve their UIM claim.
Awarding of Attorney’s Fees for Filing of a Groundless Claim

Insurer plaintiff was subject to paying attorney fees for litigating a groundless suit for three years. Plaintiff was seeking a subrogation action claiming the defendant was negligent in servicing an automobile resulting in an automobile fire. Plaintiff, prior to the filing of the suit, was given an expert opinion that the cause of the fire was merely accidental. The court found that the suit brought by the plaintiff was groundless due to there being no facts that demonstrated defendant’s negligence. The consequence of this needless litigation was a dismissal of the suit and awarding of attorney fees to the defendant.

b. Premises Liability Decision


Duty of Landowner to Licensee

The plaintiff came onto the defendant’s lakeside property and sat in the defendant’s hammock hung between two trees. One of these trees fell and seriously injured the plaintiff. The plaintiff filed suit alleging that the defendant should not have attached the hammock to that tree. Because the plaintiff was not invited onto the land, he was deemed a licensee. To a licensee, a landowner only owes a duty to abstain from willful or wanton injury to the licensee or to warn the licensee of any latent danger known to the owner. The court concluded there was no evidence that the defendant knew the tree was a danger, and found in favor of the defendant.

c. Other Significant Decisions


Intentional Interference

Plaintiff appealed summary judgment in favor of defendants on the claim that defendants intentionally interfered with her partnership agreement with her law firm, causing her to be removed as a partner. The court held that it is a matter of fact for a jury to weigh the evidence and competing inferences and to determine whether: 1) defendant intended to interfere with plaintiff’s partnership agreement; 2) defendant was certain or substantially certain to interfere; or 3) whether defendant’s threat to withdraw all business from plaintiff’s partnership was merely an expression of a client’s legitimate concern about a conflict of interest.
Attorney’s Fees for Unreasonable Litigation

A high school student was too sick to participate in class or athletics his junior year. He applied for an extra year of eligibility, which was denied by the Indiana High School Athletic Association (IHSAA). After years of lawsuits and appeals, the student continually prevailed in court, but the IHSAA wouldn’t stop challenging the ruling. The court upheld a trial court’s decision to award attorney’s fees because the IHSAA’s continual litigation became frivolous, unreasonable, and groundless.

Jury Discretion in Awarding Damages

In returning a verdict for the defendant at trial, the jury determined that the damages totaled $5,000,000.00 for the defendant. However, when considering comparative fault, the jury determined that the plaintiff was 75% at fault and the defendant was 25% at fault. In light of this, the jury reduced the damages awarded to the defendant to $3,900,000.00. The plaintiff appealed, claiming that because the damages were similar to the insurance policy limits, the jury had not actually considered defendant’s comparative fault. The court held that the reduction of damages from $5,000,000.00 to $3,900,000.00, in consideration of the comparative fault, indicated that the jury had appropriately exercised its discretion.

Direct Action Rule

A motorist injured by the tortfeasor sought to file a lawsuit directly against the tortfeasor’s liability insurer. The court ruled that because the motorist/plaintiff is not party to the insurance contract, he has no standing to file against the tortfeasor’s insurer.
D. **Significant Cases Pending Before the Indiana Supreme Court**


Admissibility of UM Insurance Limits

At trial, the plaintiff introduced evidence of the monetary limit for his uninsured motorist (UM) coverage. The Supreme Court will be determining whether introduction of an insured’s insurance limit is admissible when determining damages.


Defining Professional Services

Insured allegedly conspired with managed-care organizations to deny, delay, and diminish payments to doctors, and was sued. Insured’s policy covered wrongful acts by insured only if such wrongful acts occurred solely in the rendering of or failure to render professional services. Accordingly, the Supreme Court will be determining whether Insured’s acts of denying, delaying, and diminishing payments to doctors are considered professional services.

These cases were pending at the time this summary was printed. To confirm whether the Supreme Court has issued a decision in any of these cases, we invite you to visit our website at [http://www.smithrolfes.com](http://www.smithrolfes.com).

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VI. THE STATE OF MICHIGAN

A. FREQUENTLY CITED MICHIGAN STATUTES

1. General Considerations in Insurance Claims Management

M.C.L.A. § 29.4
Reporting of Fires; Release of Information by Insurance Companies

Fire investigators and fire prevention officials may request an insurer investigating a fire loss of real or personal property release all information in possession of the agent relative to the loss. If an insurer has reason to suspect a fire loss was caused by incendiary means, the insurer must notify the fire investigating agency and furnish them with all relevant material acquired during its investigation of the fire loss.

M.C.L.A. § 29.6
Fire Marshal Investigative Authority

State fire marshal may investigate and inquire into fire cause and origin that results in death or property damage, and without restraint or trespass liability.

M.C.L.A. § 257.1106
Death, Injury or Damages Caused by Uninsured Motorist; Application for Payment From Fund

Where the death of or personal injury or property damage to any person or property is occasioned by an uninsured motor vehicle, any person who would have a cause of action against the owner or driver of the uninsured motor vehicle in respect to the death or personal injury or property may make application for payment out of the Motor Vehicle Accident Claims Act fund for all damages in respect to the death or personal injury and for damages in excess of $200.00 in respect to property damage.

M.C.L.A. § 257.1123
Maximum Payments for Death, Injury or Property Damage

In respect to applications under the Motor Vehicle Accident Claims Act for payment of damages arising out of motor vehicle accidents, the secretary shall not pay out of the fund:

(1) More than $20,000.00, exclusive of costs, on account of injury to or the death of one person, and, subject to such limit for any one person so injured or killed, not more than $40,000.00, exclusive of costs, on account of injury to or the death of two or more persons in any one accident; and

(2) More than $10,000.00, exclusive of costs, for loss of or damage to property resulting from any one accident.

M.C.L.A. § 436.1801(3)
Liquor Liability

Right of action of person killed, injured, or damaged by unlawful sale or providing of alcohol to minor or visibly intoxicated person, if the unlawful sale is proven to be a proximate cause of the damage, injury or death.
M.C.L.A. § 500.2006
Timely Payment of Claims or Interest; Proof of Loss; Calculation of Interest; Exemptions

An insurer must pay on a timely basis to its insured the benefits provided under the terms of its policy, or, in the alternative, the insurer must pay to its insured twelve percent interest on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims is an unfair trade practice unless the claim is reasonably in dispute.

An insurer shall specify, in writing, the materials that constitute a satisfactory proof of loss not later than thirty (30) days after receipt of a claim, unless the claim is settled within the thirty (30) days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss shall be considered paid on a timely basis if paid within sixty (60) days after receipt of proof of loss by the insurer.

M.C.L.A. § 500.2026
Unfair Claims Practices

(1) Unfair or deceptive acts or practices in the business of insurance include, but are not limited to:

a) Misrepresenting pertinent facts or insurance policy provisions relating to coverage at issue;

b) Failing to acknowledge promptly or to act reasonably and promptly upon communications with respect to claims arising under insurance policies;

c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

d) Refusing to pay claims without conducting a reasonable investigation based upon the available information;

e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; and

f) Failing to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(2) The failure of an insurer to maintain a complete record of all the complaints of its insureds which it has received since the date of the last examination is an unfair method of competition and unfair or deceptive act or practice in the business of insurance.

M.C.L.A. § 500.2845
Insured Real Property Fire Proceeds

If a claim is filed for a loss to insured real property due to fire or explosion and a final settlement is reached on the loss to the insured real property, an insurer shall withhold from payment twenty-five (25) percent of the actual cash value of the insured real property at the time of the loss or twenty-five (25) percent of the final settlement, whichever is less. For residential property, the twenty-five (25) percent settlement or judgment withheld shall not exceed $6,000.00 adjusted annually beginning June 1, 1999, in accordance with the Consumer Price Index.
M.C.L.A. § 500.4503
Fraudulent Insurance Acts

In general, a person commits insurance fraud if they present or prepare any oral or written statement supporting an application or claim for insurance while knowing the statement is false, either in whole or in part.

M.C.L.A. § 500.4507
Release of Information to Authorized Agency or Insurer

Upon written request by an authorized agency, an insurer may release to the authorized agency, at the authorized agency's expense, any or all information that is considered important relating to any suspected insurance fraud. An authorized agency may release information on suspected insurance fraud to an insurer upon a showing of good cause. This information may include, but is not limited to, the following:

1. Insurance policy information relevant to an investigation, including any application for a policy;
2. Policy premium payment records that are available;
3. History of previous claims made by the insured; and/or
4. Information relating to the investigation of the suspected insurance fraud, including statements of any person, proofs of loss, and notice of loss.

M.C.L.A. § 500.4509
Report of Information Concerning Insurance Fraud

In the absence of malice in a prosecution for insurance fraud, any person who cooperates with an authorized agency or complies with a court order to provide evidence or testimony is not subject to civil liability with respect to any act concerning the suspected insurance fraud, unless that person knows that the evidence, information, testimony, or matter contains false information pertaining to any material fact or thing.

M.C.L.A. § 500.4511
Violations; Penalties

A person who commits insurance fraud is guilty of a felony punishable by imprisonment for not more than four (4) years or a fine of not more than $50,000.00, or both, and restitution. A person who enters into an agreement or conspiracy to commit insurance fraud is guilty of a felony punishable by imprisonment for not more than ten (10) years or by a fine of not more than $50,000.00, or both, and shall be ordered to pay restitution.
2. Automobile Insurance

M.C.L.A. § 500.3009
Minimum Auto Insurance Limits

An automobile liability policy insuring against loss resulting from liability imposed by law for property damage, bodily injury, or death suffered by any person arising out of the ownership, operation, maintenance, or use of a motor vehicle shall not be issued to any motor vehicle unless the liability coverage is subject to a limit, exclusive of interest and costs of:

(1) Not less than $20,000.00 because of bodily injury to or death of one person in any one accident, and subject to that limit for one person;

(2) To a limit of not less than $40,000.00 because of bodily injury to or death of two or more persons in any one accident; and

(3) To a limit of not less than $10,000.00 because of injury to or destruction of property of others in any accident.

M.C.L.A. § 500.3010
Loss or Damage Caused by Fire or Explosion to Motor Vehicle

An automobile insurer shall not pay a claim of $2,000.00 or more for loss or damage caused by fire or explosion to an insured motor vehicle until a report has been submitted to the fire or law enforcement authority designated and the insurer has received from the insured a copy of the report.

This section does not apply to accidental fires or explosions. If the insurer or the fire or law enforcement authority designated determines that the fire or explosion may not be accidental, the insurer shall notify the insured of the requirement for a report under this section by no later than thirty (30) days after the determination.

M.C.L.A. § 500.3105
Personal Protection Benefits; Accidental Bodily Injury

(1) Under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle.

(2) Personal protection insurance benefits are due without regard to fault.

(3) Bodily injury includes death resulting therefrom and damage to or loss of a person's prosthetic devices in connection with the injury.

(4) Bodily injury is accidental as to a person claiming personal protection insurance benefits unless suffered intentionally by the injured person or caused intentionally by the claimant. Even though a person knows that bodily injury is substantially certain to be caused by his act or omission, he does not cause or suffer injury intentionally if he acts or refrains from acting for the purpose of averting injury to property or to any person, including himself.
M.C.L.A. § 500.3107
Allowable Medical Expenses and Accommodations

Personal protection insurance benefits are payable for the following:

(1) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services, and accommodations for an injured person's care, recovery, or rehabilitation;

(2) Work loss consisting of loss of income from work an injured person would have performed during the first three (3) years after the date of the accident if he or she had not been injured. The statutory maximum is based upon a schedule which is periodically adjusted for inflation; and

(3) Replacement services or expenses, not exceeding $20.00 per day, reasonably incurred in obtaining ordinary and necessary services in lieu of those that, if he or she had not been injured, an injured person would have performed during the first three (3) years after the date of the accident, not for income but for the benefit of himself or herself or of his or her dependent.

M.C.L.A. § 500.3112
Payees of Personal Protection Benefits; Payments as Discharge of Liability

Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer of personal protection insurance benefits discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment, the insurer and the claimant may apply to the circuit court for an appropriate order. In the absence of a court order the insurer may pay:

(1) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor; and

(2) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

M.C.L.A. § 500.3113
Persons Not Entitled to Personal Protection Benefits

A person is not entitled to be paid personal protection insurance benefits for accidental bodily injury if at the time of the accident:

(1) The person was using a motor vehicle or motorcycle which he or she had taken unlawfully, unless the person reasonably believed that he or she was entitled to take and use the vehicle;

(2) The person was the owner or registrant of a motor vehicle involved in the accident and failed to maintain the security for payment of benefits under personal and property protection insurance; and/or
The person was not a resident of Michigan, was an occupant of a motor vehicle not registered in Michigan, and was not insured by an insurer which has filed a certification for nonresidents.

3. General Liability Considerations

M.C.L.A. § 418.131
Employer-Employee Recovery; Remedies

The right to the recovery of workers’ compensation benefits shall be the employee’s exclusive remedy against the employer for a personal injury or medical condition resulting from the employment. An employer can be held liable for an intentional tort where an employee is injured as a result of a deliberate act of the employer and the employer specifically intended the injury. An employer is presumed to have intended to injure the employee if the employer had knowledge that an injury was certain to occur and willfully disregarded that knowledge.

M.C.L.A. § 600.1483
Medical Malpractice Damages Cap

In a medical liability action, total noneconomic damages recoverable by all plaintiffs against all defendants are limited to $280,000.00, adjusted annually for inflation, except in cases where the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, or where the plaintiff had permanently impaired cognitive capacity, or the plaintiff has had a permanent loss of or damage to a reproductive organ, then noneconomic damages shall not exceed $500,000.00.

M.C.L.A. § 600.2913
Parental Liability for Minor Child’s Willful Injury or Damage

Person can recover damages for maximum of $2,500.00 from parents of resident minor child of parents when the minor has willfully or maliciously caused injury or damaged property.

M.C.L.A. § 600.2922
Wrongful Death Actions

Whenever the death of a person is caused by a wrongful act, neglect, or fault of another and the act would have entitled the party injured to maintain an action and recover damages if death had not ensued, the party that would have been liable shall be liable to an action for damages. Every action under this section shall be brought by, and in the name of, the personal representative of the estate of the deceased. The people entitled to damages by being damaged by the death only include the decedent’s spouse, parents, children, descendants, grandchildren, brothers and sisters, grandparents, the children of the decedent’s spouse, and those who are devisees under the will of the deceased, and those entitled to share in the state under the laws of intestate succession.
M.C.L.A. § 600.2925a
Contribution Between Tortfeasors

When two or more persons become jointly or severally liable in tort for the same injury to a person or property, there is a right of contribution among them even if a judgment has not been recovered against all or any of them.

The right of contribution exists only in favor of a tortfeasor who has paid more than his pro rata share of the common liability, and his total recovery is limited to the amount paid by him in excess of his pro rata share. A tortfeasor against whom contribution is sought shall not be compelled to make contribution beyond his own pro rata share of the entire liability.

M.C.L.A. § 600.2946
Product Liability Actions

A manufacturer or seller is not liable unless a plaintiff establishes that the product was not reasonably safe at the time the specific unit of the product left the control of the manufacturer or seller and, according to generally accepted production practices at the time, a practical and technically feasible alternative production practice was available that would have prevented the harm without significantly impairing the usefulness or desirability of the product to users and without creating equal or greater risk of harm to others.

There is a rebuttable presumption that the manufacturer or seller is not liable if the aspect of the product allegedly causing the harm was in compliance with federal or state standards, or was in compliance with regulations or standards relevant to the event causing the death or injury promulgated by a federal or state agency responsible for reviewing the safety of the product.

M.C.L.A. § 600.2946a
Product Liability Actions; Caps on Damages

In an action for product liability, the total noneconomic damages shall not exceed $280,000.00, adjusted annually for inflation, unless the defect in the product caused either the person’s death or permanent loss of a vital bodily function, in which case the total amount of damages for noneconomic loss shall not exceed $500,000.00.

In awarding damages in a product liability action, the trier of fact shall itemize damages into economic and noneconomic losses. Neither the court nor counsel for a party shall inform the jury of the limitations. The court shall adjust an award of noneconomic loss to conform to the limitations.

M.C.L.A. § 600.2959
Comparative Fault

In a tort action, the court shall reduce the damages by the percentage of comparative fault of the person upon whose injury or death the damages are based. If the plaintiff’s percentage of fault is greater than the aggregate fault of the other person or persons, whether or not parties to the action, the court shall reduce economic damages by the percentage of comparative fault of the person upon whose injury or death the damages are based, and noneconomic damages shall not be awarded.
M.C.L.A. § 600.6304
Joint and Several Liability

The trier of fact must allocate liability among nonparties, even in medical malpractice cases where the plaintiff is not at fault, before joint and several liability is imposed on each defendant. Once joint and several liability is determined to apply, joint and several liability prohibits the limitation of damages to each defendant’s respective percentage of fault.

M.C.L.A. § 691.1407
Governmental Immunity From Tort Liability

A governmental agency is immune from tort liability if the governmental agency is engaged in the exercise or discharge of a governmental function.

An officer, employee, member, or volunteer of the governmental agency is immune from tort liability caused while acting on behalf of the government agency if the following three conditions are met:

(1) The officer, employee, member, or volunteer is acting or reasonably believes he or she is acting within the scope of his or her authority;

(2) The governmental agency is engaged in the exercise or discharge of a governmental function; and

(3) The officer's, employee's, member's, or volunteer's conduct does not amount to negligence that is the proximate cause of the injury or damage.

4. Miscellaneous Statutes

M.C.L.A. § 24.264
Declaratory Judgment Actions

Unless an exclusive procedure or remedy is provided by a statute governing the agency, the validity or applicability of a rule may be determined in an action for declaratory judgment when the court finds that the rule or its threatened application interferes with or impairs, or imminently threatens to interfere with or impair, the legal rights or privileges of the plaintiff.

M.C.L.A. § 600.2157
Waiver of Physician-Patient Privilege

In any personal injury suit, if the plaintiff produces a physician as a witness who has treated the patient for the injury or for any disease or condition for which the malpractice is alleged, that patient is considered to have waived the privilege provided in this section as to another physician who has treated the patient for the injuries, disease, or condition.
M.C.L.A. § 600.6303
Collateral Source Benefits; Subrogation

In a personal injury action in which the plaintiff seeks to recover expenses, evidence that the expense or loss was paid or is payable by collateral source is admissible. The collateral source provider is joined after a verdict for the plaintiff is rendered and before a judgment is entered on the verdict. If the court determines that all or part of the plaintiff’s economic damages are payable by a collateral source, the court will reduce the part of the judgment which represents damages paid or payable. This reduction shall not exceed the amount of the judgment for economic loss or that portion of the verdict which represents damages paid or payable by a collateral source.

Within ten (10) days after a verdict for the plaintiff, plaintiff’s attorney shall send notice of the verdict to all persons entitled by contract to a lien against the proceeds of plaintiff’s recovery. If a contractual lienholder does not exercise the lienholder’s right of subrogation within twenty (20) days after receipt of the notice of the verdict, the lienholder shall lose the right of subrogation.
**B. MICHIGAN STATUTES OF LIMITATIONS**

<table>
<thead>
<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Libel, Defamation, or Slander</td>
<td>One year for an action charging libel or slander.</td>
</tr>
<tr>
<td>M.C.L.A. § 600.5805(9)</td>
<td></td>
</tr>
<tr>
<td>Disability of Infancy or Insanity at Accrual of Claim</td>
<td>If the person entitled to bring an action is under eighteen years of age or not mentally competent at the time the claim accrues, the person shall have one year after the disability is removed, through death or otherwise, to make the entry or bring the action.</td>
</tr>
<tr>
<td>M.C.L.A. § 600.5851</td>
<td></td>
</tr>
<tr>
<td>Actions for Personal or Property Protection Benefits; Notice of Injury</td>
<td>An action for recovery of personal protection insurance benefits for accidental bodily injury may not be commenced later than one year after the date of the automobile accident causing the injury unless written notice of injury has been given to the insurer within one year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury.</td>
</tr>
<tr>
<td>M.C.L.A. § 500.3145</td>
<td>An action for recovery of property protection insurance benefits shall not be commenced later than one year after the accident.</td>
</tr>
<tr>
<td><strong>Claim Type/Section</strong></td>
<td><strong>Statute Period</strong></td>
</tr>
<tr>
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</tr>
<tr>
<td>Assault, Battery, or False Imprisonment</td>
<td>Two years for a person charging assault, battery, or false imprisonment. Five years for a person charging assault or battery against: his or her spouse or former spouse, an individual with whom he or she has a child in common, an individual with whom he or she has had a dating relationship, or a person with whom he or she resides or formerly resided.</td>
</tr>
<tr>
<td>M.C.L.A. § 600.5805(2)-(4)</td>
<td></td>
</tr>
<tr>
<td>Malicious Prosecution</td>
<td>Two years from the date of the underlying criminal action being terminated in favor of the accused.</td>
</tr>
<tr>
<td>M.C.L.A. § 600.5805(5)</td>
<td></td>
</tr>
<tr>
<td>Medical Malpractice</td>
<td>Two years for an action charging malpractice, or within six months after the plaintiff discovers, or should have discovered, the existence of the claim, whichever is later. However, except as otherwise provided in section 600.5851(7) or (8) regarding minors, the claim shall not be commenced later than six years after the date of the act or omission that is the basis of the claim.</td>
</tr>
<tr>
<td>M.C.L.A. § 600.5805(6), § 600.5838(a)</td>
<td></td>
</tr>
<tr>
<td>Fraudulent Concealment of Claim or Identity of Person Liable, Discovery</td>
<td>If a person who is or may be liable for any claim fraudulently conceals the existence of the claim from the knowledge of the person entitled to sue on the claim, the action may be commenced at any time within two years after the person who is entitled to bring the action discovers, or should have discovered, the existence of the claim, although the action would otherwise be barred by the period of limitations.</td>
</tr>
<tr>
<td>Claim Type/Section</td>
<td>Statute Period</td>
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<td>----------------------------------------</td>
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</tr>
<tr>
<td>Bodily Injuries for Claims Not Otherwise Specified by Statute</td>
<td>Actions to recover damages for injuries to person or property must be brought within three years from the time of accrual.</td>
</tr>
<tr>
<td>M.C.L.A. § 600.5805(10)</td>
<td></td>
</tr>
<tr>
<td>Wrongful Death</td>
<td>Three years after the time of the death for all actions to recover damages for the death of a person.</td>
</tr>
<tr>
<td>M.C.L.A. § 600.5805(10)</td>
<td></td>
</tr>
<tr>
<td>Product Liability Claims</td>
<td>Three years from when the cause of action accrues. The cause of action accrues when a plaintiff by exercise of reasonable diligence discovers, or should have discovered, that he or she has a possible cause of action. However, in the case of a product that has been in use for not less than ten years, the plaintiff, in proving a prima facie case, shall be required to do so without benefit of any presumption.</td>
</tr>
<tr>
<td>M.C.L.A. § 600.5805(13)</td>
<td></td>
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<tr>
<td>Breach of Contract for Written or Oral Sale</td>
<td>Four years from when the cause of action has accrued. A cause of action accrues when the breach occurs, regardless of the aggrieved party’s lack of knowledge of the breach. By the original agreement the parties may reduce the period of limitation to not less than one year, but may not extend it.</td>
</tr>
<tr>
<td>M.C.L.A. § 440.2725</td>
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<tr>
<td>Claim Type/Section</td>
<td>Statute Period</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
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</tr>
<tr>
<td>Damages for Breach of Contract  M.C.L.A. § 600.5807(8)</td>
<td>Six years for actions to recover damages or sums due for breach of contract, starting from the date that the claim accrued.</td>
</tr>
<tr>
<td>Damage to Property by Engineers, Contractors, Architects M.C.L.A. § 600.5839(1)</td>
<td>Six years for actions against architects, professional engineers, or contractors arising from improvements to real property.</td>
</tr>
<tr>
<td>Death or Injury Arising from Improvements to Real Property M.C.L.A. § 600.5839</td>
<td>Six years after the time of occupancy of the completed improvement, use, or acceptance of the improvement, or one year after the defect is discovered, or should have been discovered, provided the defect constitutes the proximate cause of the injury or damage and is the result of gross negligence. No such action shall be maintained for more than ten years after the time of occupancy of the completed improvement, use or acceptance of the improvement.</td>
</tr>
<tr>
<td>Uninsured/Underinsured Motorist Coverage M.C.L.A. § 600.5807(8)</td>
<td>In the absence of a contractual limitations provision, suit for UM/UIM benefits is governed by the six-year statute of limitations applicable to contract actions, not the three-year period applicable to claims for injury to person or property.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreclosure of Mortgages M.C.L.A. § 600.5803</td>
<td>No person shall bring or maintain any action or proceeding to foreclose a mortgage on real estate unless he commences the action or proceeding within fifteen years after the mortgage becomes due or within fifteen years after the last payment was made on the mortgage.</td>
</tr>
</tbody>
</table>
C. **Significant Michigan Court Decisions**

1. **Supreme Court Decisions**

   a. **Insurance Coverage Decisions**


   **The Insured Must Submit Proof of the Actual Loss and Cost of Repairs Associated With a Fire Resulting in Damage to Her Home in Accordance With the Policy Provisions to Recover the Withheld Depreciation**

   Plaintiff’s home and personal property were destroyed in a fire. Plaintiff demanded an appraisal, and the appraisal panel entered an award detailing RCV and ACV figures. The company paid the actual cash value based upon the appraisal award. The plaintiff demanded payment of the full replacement cost without repairing the property, and when it was rejected, filed suit. The trial court and the appellate court ruled in favor of the insured which would have required payment in full of the replacement costs without proof of actual repair or replacement as required by the policy of insurance. The Supreme Court reversed, holding the policy provisions continued to control and an appraisal award cannot change the terms of the policy. The insured was only entitled to recover the actual cash value from the appraisal award, until proof of replacement was submitted.


   **Independent Contractor Not an Employee for Worker Compensation Purposes**

   Defendant originally brought a negligence suit against his “employer” and plaintiff’s insured for no-fault benefits arising from injuries sustained in a work-related accident. The “employer’s” insurer then filed a declaratory judgment action seeking a declaration the defendant was an “employee” and eligible for workers compensation benefits and, as such, not eligible for no-fault benefits under the “employer’s” commercial auto policy with plaintiff. The insurer moved for summary judgment, which was denied by the trial court on the basis the defendant was not an employee, but an independent contractor and, as such, the general liability policy and no fault policy applied to his negligence and no fault claims. A special panel was convened as requested by the court of appeals and it reversed the trial court's order determining defendant was not an independent contractor because it did not meet all of the criteria in MCL 418.161(1)(n) to be divested of employee status. Thus the special panel concluded that defendant was an employee and only the workers compensation coverage applied. The Supreme Court overruled the special panel of the court of appeals and upheld the opinion that the defendant was an independent contractor because he did not meet all three criteria of the statute, i.e., that 1) defendant did not maintain a separate business, 2) defendant did not hold himself or herself out to and render service to the public, and 3) defendant was not an employer subject to the WDCA.
b. No-fault/PIP Decision


Evidence Must Show Plaintiff Knew Vehicle Was Stolen to Deny PIP Benefits

Plaintiff brought an action against the defendants, seeking payment of PIP benefits under Michigan’s no-fault act, MCL 500.3101, after he was injured while riding a stolen motorcycle. Plaintiff had borrowed the motorcycle and did not know it was stolen. Defendants denied plaintiff’s claims for PIP benefits and asserted that plaintiff had taken the motorcycle unlawfully and was barred from recovering PIP benefits by the unlawful-taking exclusion of MCL 500.3113(a). The issue before the court was whether MCL 750.414, which makes it a misdemeanor to take or use a vehicle without authority of its owner, requires intent or knowledge for purposes of applying MCL 500.3113(a). The court held that MCL 750.414 is not a strict liability crime, and the defendants could not deny PIP benefits unless the evidence established the plaintiff knew the motorcycle he had taken was stolen.

c. Other Significant Decisions


Court May Award Case Evaluation Costs After Granting Motion for Entry of Judgment

Plaintiff brought an action against the defendant to recover losses suffered in a fire on the plaintiff’s property. The case proceeded to case evaluation, which resulted in a favorable award for the plaintiff. Defendant rejected the award and the parties agreed to submit the matter to an appraisal panel. The result was a more favorable award for the plaintiff, who then moved for entry of a judgment and sought case evaluation costs under MCR 2.403(O)(1). The court held that under MCR 2.403(O)(2)(c), the definition of “verdict” includes a judgment entered as a result of a ruling on a motion after rejection of the case evaluation. Therefore, when a party rejects a case evaluation, an appraisal panel’s award is less favorable to that party, and the court grants the opposing party’s motion for entry of judgment, actual costs may be awarded to the prevailing party.

Subcontractor Indemnity Clause Extends to Failure to Do Corrective Work

Plaintiff general construction contractor contracted with defendant subcontractor roofer in connection with the construction of an indoor pool at the YMCA. The contract contained an express indemnification clause. The roofer’s work was negligently performed, and the general contractor undertook corrective measures, and incurred additional expense, to cure the defects, without litigation with the project owner. The court of appeals found that the statute of limits barred the action and the indemnity clause did not apply since no claim was brought against plaintiff. The Supreme Court of Michigan reversed, first finding the general was clearly entitled to prosecute its indemnification claim against the roofer regardless of whether the general contractor and the project owner had litigated the negligent workmanship/corrective action issue or not.

2. Appellate Court Decisions

a. Insurance Coverage Decisions

http://publicdocs.courts.mi.gov:81/OPINIONS/FINAL/COA/20140306_C312485_54_312485.OPN.PDF

Act of Insured Does Not Void Mortgage Clause Between Insurer and Mortgagee

A resident mortgaged and insured a house, then sold the house to his sister-in-law. However, he failed to change the named insured when he transferred the mortgage to his sister-in-law. After a fire destroyed the house, the insurer denied the sister-in-law’s claim as excluded under the policy since the named insured did not reside at the address. The trial court found that since the residence was not covered under the policy, the policy’s mortgage clause did not extend coverage to the mortgagee bank. The appellate court reversed, holding the standard mortgage clause at issue was an independent contract between mortgagee and insured which could not be voided by acts of the insured.


A Jury Verdict in Favor of a Plaintiff in a Medical Malpractice Case Against One Tortfeasor Must be Reduced by the Entire Amount of Settlement Proceeds Paid by Another Tortfeasor

Plaintiffs, two parents and a newborn, filed suit against multiple defendants in a medical malpractice action alleging horrific injuries to the newborn. Defendant hospital settled pre-suit with plaintiffs for $600,000.00. The jury awarded plaintiffs $1,058,825.56 at trial against the physician. The trial court only permitted the physician to receive a $200,000.00 set off because
the jury determined only one of the three plaintiff’s (the infant) sustained injury. The appellate court reversed, holding the physician was entitled to the $600,000.00 set off.


_for a Conservator to be Eligible for Personal Injury Protect Benefits, Their Fees Must be for Allowable Expenses Directly Related to the Accident at Issue._

Plaintiff sued seeking payment of PIP benefits to cover conservator fees for the care of an individual injured in an automobile accident. The appellate court held that for a conservator to be eligible for such benefits, their fees must be classified as allowable expenses. Allowable expenses must be causally connected to or necessitated by the automobile accident. Allowable expenses do not include expenses for activities the individual would perform were they not injured. Maintenance of the individual’s household and settling litigation unrelated to the accident are not allowable expenses. However, costs associated with maintaining conservatorship is an allowable expense.


_conflicting ordinary and standard loss payable clauses render an insurance contract ambiguous, necessitating a jury trial._

Plaintiff was the previous owner of a property insured by the defendants, and was listed as an “Additional Interest” and “Land Contract Holder” on the subsequent purchaser’s commercial insurance policy. Coverage for fire loss was denied to the purchaser due to allegations of fraud. The dispute arose from conflicting clauses in the contract; one limiting the plaintiff’s recovery to those allowed the insured, and another guaranteeing the plaintiff full recovery without limitation. Based on the ambiguity generated by these conflicting clauses, it was improper for the trial court to dismiss the insured plaintiff’s claim on summary judgment, and the case was remanded for jury trial.


_modifications to vehicles rendering them unfit for use on public roadways exclude them from motor vehicle insurance statues, and estoppel cannot be used to expand available insurance coverage._

The appellate court reversed a lower court’s holding that the plaintiff was owed Personal Injury Protection benefits following a collision with a modified jeep while off-roading. The court determined that the jeep had been sufficiently modified to render it unusable on public roads, and
thus fell outside statutory regulations concerning the insurance of automobiles. Because ORVs are statutorily excluded from no fault coverage, the policy did not need to expressly exclude them as well. This classification also precluded coverage by out of state insurance, because the accident was not one to which the policy applies. Although the defendants did not initially cite the vehicle’s ORV status when denying the claim, the waiver of that right cannot be used by the plaintiff to expand coverage beyond the initial bounds of the policy.


A Motion for Judgment Notwithstanding the Verdict is Improper, but a Motion for a New Trial is Permissible When Evidentiary Irregularities Undermine the Trial Verdict

Plaintiff restaurant owner and defendant insurance company were in dispute over a fire loss claim. The insurer alleged fraud and arson in defense of its denial of payment. Unchallenged evidence admitted at trial included the prior statements of a fugitive arsonist and substantial accounting information. Much of the evidence was superfluous, hearsay, or otherwise inadmissible. Based on the evidentiary dispute, the trial court erred in issuing a judgment notwithstanding the verdict for the plaintiff, but was correct in granting a motion for a new trial.


In Determining Whether an Individual is “Totally Disabled,” Adequate Weight Must be Given to Parties’ Medical Evaluation

Plaintiff was suffering from a spinal impairment and chronic pain following an unsuccessful surgery to correct the problem. Plaintiff claimed long term disability status and defendant commissioned an independent medical examination which found plaintiff retained limited capacity to work in certain sedentary positions. Based on this examination, defendant denied plaintiff the benefits of its long term disability plan. On appeal, the court determined that defendant was unreasonably dismissive of plaintiff’s more thorough medical evidence, and thus its failure to classify the plaintiff as long term disabled was impermissible.


The One-Year-Back Rule Applies to Any Claim for the Recovery of PIP Benefits

Plaintiff bicycle rider, a minor, was injured after being struck by defendant motorist. Plaintiff sued the defendant and plaintiff’s mother’s insurer which paid the claim. At trial, plaintiff’s insurer discovered that plaintiff was not actually covered by the insurer’s plan, and argued it should be reimbursed by defendant’s insurance, and sued defendant’s insurer. Plaintiff’s insurer
then filed a cross-claim to recover the money they had paid plaintiff. Defendant’s insurer said they did not have to pay because of the One-Year-Back Rule, which says that claims for PIP benefits as a result of accidental injury must be brought within one year of the commencing of the action. The court agreed with defendant’s insurer and held that if a claim is for the recovery of PIP benefits, the One-Year-Back Rule will apply.


**Business Insurance Does Not Cover Injuries in Company Vehicles Used Outside of Company Approved Use**

The Plaintiff was involved in an accident while transporting a customer of the dealership that she worked for to work. The plaintiff’s insurer claims that the dealership’s insurance should be responsible for paying the claim because the car was being operated in the course of business. The court determined that because the plaintiff was not supposed to be transporting the customer at the time of the accident, and because the transportation of customers in general was a small part of only 25% of business for the dealership, the insurance of the plaintiff was wholly responsible for the damages.


**Car Kept in the Belongings of a Person Qualifies Them to be the “Owner” According to the No-Fault Act**

The plaintiff was involved in an accident that fell under no-fault insurance coverage. The plaintiff did not have no-fault insurance on the car, but her parents had added the car to their insurance policy. The parent’s insurance claimed that they did not have to pay for the claim because the car was not “owned” by the plaintiff’s parents according to the no-fault act. The court found that because the car was kept by the plaintiff’s parents, the plaintiff’s parents were the only ones with keys to the car, and the plaintiff’s parents could freely drive the car whenever they wanted, the plaintiff’s parents were the “owners” of the vehicle according to the no-fault act.

**b. UM/UIM Decisions**

http://publicdocs.courts.mi.gov:81/OPINIONS/FINAL/COA/20140327_C313886_34_313886.OPN.PDF

**PIP Benefits Properly Denied Where Towed Uninsured Vehicle Injures Owner**

Plaintiff’s uninsured, inoperable vehicle was being towed on the highway when the tow chain broke, and was struck by an oncoming vehicle, injuring plaintiff and damaging the vehicle. The
trial court denied plaintiff’s no-fault PIP benefits application since the vehicle was uninsured. The appellate court agreed, holding that even if the injury arose out of the maintenance and use of the vehicle, the vehicle was uninsured and, as such, PIP benefits may not be paid to injured owner.


Owner Injured by Falling Tree Branch While Opening Car Door May Receive PIP Benefits

Plaintiff sued for PIP benefits after being injured by a falling tree branch which struck her while entering her vehicle. The trial court denied PIP benefits reasoning that plaintiff was not “entering into” the vehicle at the time. The court reversed, finding once a plaintiff makes physical contact with a vehicle for purposes of entering it, the process of “entering into” the vehicle begins. The court noted that opening the car door is a necessary part of entering into a vehicle, and there is no need for the injury to occur as a direct result of use of the vehicle.


The Insurer's Failure to Provide Its Insured With a Copy of the Auto Policy Waives the Insurer's Right to Raise Non-Compliance With Policy Provisions

Plaintiff was involved in a collision while operating her sister’s car and sued the defendant, the plaintiff’s insurer, for uninsured motorist benefits. The defendant raised “non-compliance with the policy terms” as an affirmative defense, but never provided plaintiff with a copy of the policy. On appeal, the court held that this failure to provide a copy of the policy precluded plaintiff from taking steps to adhere to the policy and, as such, the defendant waived its right to raise non-compliance as an affirmative defense.

c. Premises Liability Decisions


Homeowners Association Assumed Duty Lot, Storm Not an Intervening Cause

Plaintiff-homeowner sued defendant-homeowners association for ordinary negligence after a tree fell from an access lot and damaged the plaintiff’s home. The plaintiff had complained about the tree previously since the homeowners association maintained the access lots. The trial court dismissed the plaintiff’s case, finding a storm to be an intervening cause. The appellate court
reversed, finding that a storm is not an “intervening cause” and, because the land was in the homeowners association’s possession and control, the association voluntarily assumed the responsibility for the land and had actual and/or constructive notice of the damaged tree.


**Vicious Dog Ordinance Does Not Apply to Non-Resident Landlords**

Plaintiff sued defendant landowner after being bitten by tenant's dog that escaped from the property. Plaintiff alleged a local ordinance banning vicious dogs created a private cause of action in favor of plaintiff against the landowner. The trial court dismissed the claim finding the ordinance did not create a private right of action. Further, the court determined the landowner was not a constructive owner of the dog, since the defendant landowner did not reside at the premises where the dog was kept.


**Special Relationship Created Between Adult Providing Alcohol and Inebriated Minor**

After a night of drugs and alcohol at the defendant’s residence, defendant accidentally discharged a shotgun while putting it away and injured an underage inebriated guest. The trial court found there was no negligence on behalf of the insured and no special relationship was created between the guest and insured. The appellate court reversed, finding that the injury was foreseeable in the circumstances and a “special relationship” existed between the adult and the intoxicated minor.


**Court Adopts the “Attractive Display” Exception to the Open and Obvious Defense Doctrine in Premises Liability Cases**

Plaintiff was shopping at a self-service retail store where she tripped on a support platform beneath a cardboard display when cornering out of an aisle. The platform was of a type used to display heavy merchandise, served no role in supporting the light cardboard display on top of it, and could be easily removed. While Michigan’s open and obvious doctrine generally eliminates the duty to warn of easily discoverable hazards, individual shoppers are entitled to presume that passageways provided for their use are reasonably safe. Momentary distractions do not affect the application of the open and obvious doctrine; however the distractions in this case were continuous and created by the defendant. Store owners owe a reasonable duty to keep aisles clear
of hazards in light of their practices to distract customers gaze from such hazards to merchandise and advertising.


_A Pruned Bush Adjacent to a Grassy Path Is Not an Attendant Circumstance Which Would Render the Path “Unreasonably Dangerous”_

Plaintiff slipped on a piece of grass in the common area of her apartment complex while walking to the parking lot. As she fell, she was struck in the eye by the branch of an adjacent bush which had recently been pruned. She sued the complex, which filed a motion for summary judgment seeking dismissal of the case on the basis of the open and obvious doctrine. The motion was sustained and, on appeal, the court agreed the bush did not create an abnormally dangerous condition to preclude application of the open and obvious doctrine.


_Open and Obvious Doctrine Did Not Apply Where Property Owner Did Not Argue the Risk (Ice on a Parking Lot) Was Not Unavoidable_

Plaintiff slipped and fell on ice that was unavoidable in the parking lot of defendant, and plaintiff sued. The parties stipulated the sole issue to be determined was whether defendant owed plaintiff a legal duty of care under Michigan law. The court determined that defendant owed a duty for open and obvious hazards if the risk was either “effectively unavoidable” or posed a “substantial risk of death or serious injury.” The court concluded from the evidence the risk of harm was effectively unavoidable and, as such, the open and obvious doctrine does not vitiate defendant’s duty of care.

d. **Governmental Immunity Decision**


_Public Park Owned by Private Trustees Cannot Claim Governmental Immunity_

Plaintiff sued for wrongful death after a boy died in a sledding accident at a park. The trial court found that the park could claim governmental immunity since the park was conveyed for the use of the public and the city, even though the property did not vest to the city. The court reversed, finding the park could not claim governmental immunity as a political subdivision since the trust explicitly conveyed legal ownership of the park to private trustees rather than the city. The trust
does not qualify as a governmental agency since it operates independently and without receiving money from the city.

e. Other Significant Decisions

*Bagby v. Detroit Edison Company*, No. 311597

In an Intentional Tort Case, the Plaintiff an Employee, Must Have Actual Knowledge an Injury Was Certain to Occur

Plaintiff’s wife brought an employer intentional tort action on behalf of her husband who was working for defendant employer. The trial court denied employer’s motion for summary judgment on the basis that a general issue of material fact existed regarding whether employer had actual knowledge that an injury was certain to occur. The appellate court reversed on basis there was no evidence the employer had “actual knowledge the injury was certain to occur” because the employee’s supervisor could not have known the decisions the deceased would make under the circumstances.

http://publicdocs.courts.mi.gov:81/OPINIONS/FINAL/COA/20140225_C301783_78_301783.OPN.PDF

District Court Must Transfer or Dismiss When Amount in Controversy Exceeded $25,000.00

Plaintiff filed a complaint in district court for an amount not to exceed $25,000.00, but presented evidence far exceeding this amount at trial. The jury found for the plaintiff, and the court reduced the judgment to $25,000.00. The circuit court found for the defendant on three grounds, and the court agreed. First, since the district court did not dismiss the case or transfer it once the amount in controversy exceeded $25,000.00, the judgment was dismissed since there was no jurisdiction. Second, defendant only needed to object to the court’s jurisdiction, rather than also demand a new trial. Third, plaintiff’s repeated suggesting defendant can recover from a third-party source was independently sufficient to grant a new trial.


Otherwise Invisible Black Ice on an Icy Residential Sidewalk is an Open and Obvious Danger, Precluding Recovery for Personal Injury Resulting From a Fall on the Ice, Based Upon Attendant Circumstances.

Plaintiff slipped and fell on ice, on the only sidewalk to access her apartment, in front of her apartment and sued defendant landlord. The trial court found that the ice was an open and
obvious condition. The appellate court agreed, observing five inches of snow fell the night before, and the plaintiff observed the sidewalk “glistening.”


**An Actual Controversy Must Exist Before One May Seek and Obtain Declaratory Relief**

Plaintiff, a former general counsel, filed suit against his corporate client for terminating the attorney-client relationship. Plaintiff then filed a declaratory judgment action against former client’s insurer seeking a declaration the policy did not afford defense or indemnification coverage for the claims asserted in the plaintiff’s complaint. On appeal, the court affirmed the trial court, holding plaintiff lacked standing to bring the declaratory judgment action, and that the purpose of filing the suit was to negatively impact the relationship between the insurer and the insured.

**3. Federal Court Decisions**


**Claimant’s Omission of Claim Meets Mistake or Inadvertence Exception to Judicial Estoppel**

During an employee benefits dispute with the employer, plaintiff filed for Chapter 13 personal bankruptcy. The defendant alleged the plaintiff’s claims were judicially estopped since the plaintiff did not disclose the claim to the bankruptcy court. The trial court found that the plaintiff failed to inform the bankruptcy court by accident, noting the employee told his attorney of the claim. The court agreed, finding the failure to disclose was a careless error rather than an intentional act, which fell into the mistake or inadvertence exception to judicial estoppel.


**Use of Coroner’s Report in Connection With Cause of Death Sufficient to Deny Accidental Death Benefits**

Plaintiff sued for denial of ERISA accidental death benefits after spouse died of alcohol poisoning. Defendant used Ohio’s drunk-driving statute to determine if spouse was intoxicated as a matter of law. The trial court upheld defendant’s denial of death benefits, relying upon the coroner’s report for cause of death rather than defendant’s rationale. The appellate agreed, finding the defendant’s basic rationale was acceptable. The court also noted defendant had duty to hire a medical expert since the coroner’s report was not rebutted by plaintiff.
The Term “Obsolescence” Contained in an Insurance Policy Does Not Apply to Economic Obsolescence or a Decline in Market Value

The parties to an insurance policy disagreed regarding the amount of loss associated with damage caused by a fire. The insurer agreed to pay the “actual cash value” of the building at the time of the loss. “Actual cash value” was defined in the contract as the “replacement cost less a deduction that reflects depreciation, age, condition and obsolescence.” The court determined that the term obsolescence, as commonly understood, does not account for a decline in market value, inuring to the benefit of the insured with respect to valuation of the loss. Terms in an insurance contract provided for “actual cash value” less “a deduction that reflects depreciation, age, condition, and obsolescence.” The insurer argued that a decline in market value, referred to as “economic obsolescence” in limited contexts, should be factored into this equation. However, economic obsolescence is a specialized concept not typically associated with the general understanding of obsolescence. To the extent there is ambiguity, contracts should be interpreted in favor of the insured, precluding an economic obsolescence deduction in this instance.

Automobile Company Estopped From Asserting Claim for Tortious Interference Based Upon Having No Right to Tortious Interference Because of the Language of the Parties’ Contract

Plaintiff was formally a wholly owned subsidiary of defendant. Defendant sold its majority interest in plaintiff, but retained a minority interest of preferred stock. Plaintiff faced financial hardship and attempted to enter into investment agreements with a Chinese automobile company. Plaintiff determined that because it would go bankrupt if it did not enter into the investment agreement, plaintiff did not need approval from defendant, which disapproved the proposal. The Chinese company withdrew its offer, and plaintiff sued defendant alleging tortious interference with economic expectancy. Defendant’s motion to dismiss was granted by the trial court. The appellate court agreed, holding plaintiff failed to state a legally cognizable claim against defendant, and further determined the defendant had the right to withhold its consent to the deal under its contract with plaintiff.
D. Significant Case Pending Before the Michigan Supreme Court

Hannay v. Department of Transportation (146763)

Whether Economic Loss in the Form of Wage Loss May Qualify as a “Bodily Injury” That Permits a Plaintiff to Avoid the Application of Governmental Immunity From Tort Liability Under the Motor Vehicle Exception to Governmental Immunity, and the Evidence in This Case Establishes That the Plaintiff Incurred a Loss of Income From Work That She Would Have Performed as Opposed to a Loss of Earning Capacity

Plaintiff was injured when an employee of the defendant struck her vehicle while driving a salt truck. Plaintiff sued, arguing she suffered a serious impairment of bodily function, and that she was entitled to recover damages, including economic damages for work loss and loss of services. Defendant governmental entity argues the Michigan no-fault act limits damages to “personal injury and property damage” only, and that the scope of damages permitted to be recovered by plaintiff by the trial and appellate courts was overbroad and impermissible under Michigan law.

This case was pending at the time this summary was printed. To confirm whether the Supreme Court has issued a decision in this case, we invite you to visit our website at http://www.smithrolfes.com.

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VII. THE STATE OF FLORIDA

A. FREQUENTLY CITED FLORIDA STATUTES

1. General Considerations in Insurance Claim Management

Fla. Stat. § 86.011
Declaratory Judgments
This statute gives the circuit and county courts of Florida the authority to declare rights, status, and other equitable or legal relations whether or not further relief is or could be claimed.

Fla. Stat. § 95.03
Contract Provision Shortening Limitations Period
This statute prohibits contract provisions which mandate an action based on the contract be brought in a shorter time period than prescribed in Florida’s statute of limitations.

Fla. Stat. § 95.10
Cause of Action Arising in Another State
This statute prohibits a cause of action being brought in Florida if the cause of action arose in another state and the applicable statute of limitations of that state has lapsed.

Fla. Stat. § 626.854
Public Adjuster Prohibitions
Statute enacted to regulate public insurance adjusters and to prevent the unauthorized practice of law. The statute prohibits public adjusters from soliciting or entering into a contract with an insured or claimant within forty-eight (48) hours of a potential claim. The statute allows an insured to cancel a contract with a public adjuster within three (3) days of its signing or three (3) days following notification of the claim to an insurer without penalty to the claimant. The statute also contains provisions restricting the activities and fees allowable by public adjusters.

Fla. Stat. § 626.9521
Unfair Claims Practices; Penalties
The statute pertains to penalties imposed for an unfair or deceptive practice in the insurance business. The statute includes punitive fines for persons and insurers who commit an unfair claim practice.

Fla. Stat. § 626.9744
Settlement Practices Relating to Property Insurance
When a homeowner’s insurance policy provides for the adjustment and settlement of first-party losses based on repair or replacement cost, physical damage incurred in making a repair or replacement which is covered shall be included in the loss. When a loss requires replacement of items and the replaced items do not match in quality, color, or size, the insurer shall make reasonable repairs or replacement of items in adjoining areas, subject to consideration of relevant factors.
**Fla. Stat. § 627.405**  
**Insurable Interest Requirement for Property**

No insurance contract of property shall be enforceable except for the benefit of persons having an insurable interest in the things insured at the time of the loss. The statute defines “insurable interest” as “any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.”

**Fla. Stat. § 627.4136**  
**Nonjoinder of Insurers**

The statute requires for a person who is not an insured to obtain a settlement or verdict against a person who is an insured before a cause of action against a liability insurer can be maintained. An insurer has the right to insert a contractual provision into a liability insurance policy which precludes persons not designated as an insured from joining a liability insurer as a defendant.

**Fla. Stat. § 627.4137**  
**Disclosure of Certain Information Required**

The statute requires insurers who provide liability coverage to disclose particular information upon written request of a claimant within thirty (30) days. This disclosure must be signed by a corporate officer, the insurer’s claims manager, or superintendent, and must contain the following information: the insurer’s name, the insured’s name (or insureds’ names), the limits of the liability coverage, a statement of any policy or coverage defense which it reasonably believes applies to the situation, and a copy of the policy. An insurer has a continuing duty to update this information to the claimant immediately upon discovering new facts relevant to the statement.

**Fla. Stat. § 627.4143**  
**Outline of Coverage**

No private passenger automobile or basic homeowner’s policy shall be delivered or issued for delivery unless an outline has been delivered prior to issuance or accompanies the policy. The statute lists what an effective outline of coverage for a private passenger motor vehicle insurance policy contains. The statute also requires that a basic homeowner’s policy may not be delivered or issued unless a comprehensive checklist of coverage is delivered prior to issuance. The statute lists what the comprehensive checklist of coverage must include.

**Fla. Stat. § 627.701**  
**Liability of Insureds, Coinsurance, and Deductibles**

If an insurance policy or contract contains provisions requiring the insured to be liable as a co-insurer with the insurer issuing the policy, the statute lists the requirements the policy must meet to do so. The statute also contains restrictions on insurers and disclosure requirements for insurers for hurricane damage deductibles.

**Fla. Stat. § 627.70121**  
**Payment of Claims for Dual Interest Property**

Effective for policies issued or renewed on or after Oct. 1, 2006, a property insurer shall transmit claims payments directly to the primary policyholder, payable to the primary policyholder only, without requiring a dual endorsement from any mortgage holder or lienholder, for amounts payable for personal property and contents, additional living expenses, and other covered items that are not subject to a recorded security interest.
**Fla. Stat. § 627.70131**  
**Insurer’s Duty to Acknowledge Communications Regarding Claims; Investigation**

An insurer shall review and acknowledge receipt of a communication with respect to a claim within fourteen (14) calendar days, unless payment is made within that time period or the failure to respond is caused by factors beyond the insurer’s control. The acknowledgement requirement shall not apply to claimants represented by counsel beyond communications necessary to provide forms and instructions.

Within ten (10) working days after an insurer receives proof of loss, the insurer shall begin an investigation as is reasonably necessary.

Within ninety (90) days after an insurer receives notice of a property insurance claim, the insurer shall pay or deny such claim or a portion of the claim unless failure to pay is caused by factors outside the insurer’s control.

**Fla. Stat. § 627.7015**  
**Alternative Procedure for Resolution of Disputed Property Insurance Claims**

This statute sets forth a nonadversarial procedure for a mediated claim resolution conference as an effective, fair, and timely alternative to the traditional adversarial appraisal process.

**Fla. Stat. § 627.7016**  
**Insurer Contracts With Building Contractors**

An insurer who offers residential coverage may contract with a building contractor skilled in techniques that mitigate hurricane damage. The insurer must guarantee the building contractor’s work if the insurer offers policyholders the option to select the services of such building contractors. The insurance company is not liable for the actions of the building contractor.

**Fla. Stat. § 627.702**  
**Valued Policy Law**

This statute fixes the measure of damages payable to the insured in the amount of a total loss as the amount of money specified in the policy for which premiums were charged and paid. This statute does not deprive an insurer of any proper defense, and the insurer is never liable for more than the amount necessary to repair, rebuild, or replace the structure. An insurer is not prohibited from repairing or replacing damaged property at its own expense, without contribution on the part of the insured, except when an insured has elected to purchase stated value coverage. Any insurer may provide insurance indemnifying the insured for the difference between the value of the insured property at the time of loss and the amount expended to repair, rebuild, or replace it.

**Fla. Stat. § 627.712**  
**Residential Windstorm Coverage Required**

This statute requires an insurer issuing a residential property insurance policy to provide windstorm coverage. An insurer must make an exclusion of windstorm coverage and an exclusion of coverage of contents, available at the option of the policyholder. The statute lists criteria which must be met for such exclusions.
Fla. Stat. § 744.387
Settlement of Minor’s Claims

A settlement agreement of a minor’s claim reached after an action has been commenced must be approved by the court having jurisdiction over the action. If a settlement agreement is reached before an action is commenced, the court may authorize the settlement if it will be for the best interest of the minor. If the net settlement exceeds $15,000.00, the court shall appoint a guardian on the minor’s behalf.

2. Insurance Fraud

Fla. Stat. § 627.409
Representations in Applications and Warranties

Any statement or description made by an insured in an application for insurance is a representation. A misrepresentation, omission, or concealment of fact may prevent recovery if it is material to either acceptance of the risk or to the hazard assumed by the insurer or if the insurer, in good faith, would not have issued the policy, the same coverage, the same premium rate, or insured in as large an amount had the true facts been known.

Fla. Stat. § 627.425
Forms for Proof of Loss Furnished

On request of any person claiming to have a loss under an insurance contract, an insurer shall furnish forms of proof of loss. This statutory requirement does not include a responsibility for the completion of such proof by the insurer.

Fla. Stat. § 627.426
Claims Administration

Acknowledgement of the receipt of notice of loss or claim under a policy, furnishing forms for reporting a loss or claim, for giving information relative to a loss or claim, for making proof of loss, or investigating any loss or claim under any policy or engaging in settlement negotiations does not constitute a waiver of any provision of a policy or any defense.

A liability insurer shall not be permitted to deny coverage based on a particular coverage defense unless: (a) written notice of reservation of rights to assert a coverage defense is given to the insured within thirty (30) days after the insurer knew of the coverage defense, and (b) at least thirty (30) days before trial, the insurer gives notice of its refusal to defend the insured, obtains from the insured a nonwaiver agreement setting out the specific facts and policy provisions upon which the coverage defense is asserted, and retains independent counsel.

Fla. Stat. § 633.03
Investigation of Fire; Reports

The state fire marshal shall investigate the cause, origin, and circumstances of every fire occurring in Florida where property has been damaged or destroyed where there is probable cause to believe that the fire was the result of carelessness or design.
**Fla. Stat. § 633.818**  
*False Statements to Insurers*  
This statute deems false statements or representations by a firefighter employer to an insurer of workers’ compensation insurance a second degree misdemeanor.

### 3. Automobile Insurance

**Fla. Stat. § 324.021**  
*Minimum Insurance Required*  
This statute requires motor vehicle insurance in the amounts of:

1. $10,000.00 in case of bodily injury to, or death of, one person in any one crash;
2. $20,000.00 in case of bodily injury to, or death of, two or more persons in any one crash;
3. $10,000.00 in case of injury to, or destruction of, property of others in any one crash.

**Fla. Stat. § 626.9743**  
*Settlement Practices Relating to Motor Vehicle Insurance*  
The statute specifies prohibited conduct in settling motor vehicle insurance claims and applies to both personal and commercial claims. When liability and damages owed are reasonably clear, an insurer may not recommend that a third-party claimant make a claim on his or her own policy solely to avoid paying the claim under the policy issued by that insurer. Methods for adjustment and settlement of a motor vehicle total loss are provided and include a cash settlement, a replacement motor vehicle, or another method agreed to by the claimant.

**Fla. Stat. § 627.4132**  
*Stacking of Coverages*  
The statute prohibits stacking of insurance policies when an insured is protected by any type of motor vehicle insurance policy. The insured is only covered to the extent provided on the vehicle involved in the accident. The stacking prohibition does not apply to uninsured motorist coverage.

**Fla. Stat. § 627.7263**  
*Rental and Leasing Driver's Insurance to be Primary*  
The valid insurance providing coverage for the lessor of a motor vehicle for rent or lease is primary unless otherwise stated. If the lessee’s coverage is to be primary, the statute sets out the specific language which the lease agreement must contain in order for such coverage to be effective.

**Fla. Stat. § 627.727**  
*Uninsured and Underinsured Motor Vehicle Coverage*  
No motor vehicle liability insurance policy shall be issued unless uninsured motor vehicle (UMV) coverage is provided therein. An insured may make a written rejection of the coverage on behalf of all insureds under the policy. If the motor vehicle is leased, the lessee has the sole privilege to reject uninsured motorist coverage. The insurer shall notify the insured at least annually of the insured’s options as to UMV coverage.

The term “uninsured motor vehicle” includes an insured motor vehicle when the liability insurer thereof: (a) is unable to make payment with respect to the liability of its insured due to its
insolvency, (b) has provided limits of bodily injury liability for its insured which are less than the total damages sustained by the person entitled to recover damages, or (c) excludes liability to a nonfamily member whose operation of an insured vehicle results in injury to the named insured.

**Fla. Stat. § 627.7275**
**Motor Vehicle Liability**

A motor vehicle insurance policy providing personal injury protection must also provide coverage for property damage liability. Insurers shall make coverage available for bodily injury, death, and property damage arising out of ownership, use, or maintenance of a motor vehicle in an amount not less than $10,000.00 for injury or death of one person in any one crash, $20,000.00 for injury or death of two or more persons in any one crash, and coverage available for property damage in an amount not less than $10,000.00 for the injury or destruction of another’s property.

**Fla. Stat. § 627.730**
**Florida Motor Vehicle No-Fault Law**

Florida statutes within the range of section 627.730 to section 627.7405 may be cited and known as the “Florida Motor Vehicle No-Fault Law.”

**Fla. Stat. § 627.736**
**Required Personal Injury Protection Benefits, Exclusions, Priority, and Claims**

This statute provides required insurance policy benefits, including, to a limit of $10,000.00, eighty (80) percent of all reasonable expenses for necessary medical services, sixty (60) percent of any loss of gross income and loss of earning capacity per individual from inability to work, and death benefits equal to the lesser of $5,000.00 or the remainder of unused personal injury protection benefits per individual.

This statute also authorizes exclusions of benefits for injuries sustained while occupying another motor vehicle owned by the insured and not insured under the policy, for injury sustained by any person operating the insured motor vehicle without consent, for injury caused to one’s self intentionally or for injury sustained while committing a felony.

**Fla. Stat. § 627.737**
**Tort Exemptions; Limitation on Right to Damages; Punitive Damages**

This statute exempts owners and operators of motor vehicles from tort liability to the extent that the benefits required for personal injury protection under Fla. Stat. §627.736 are applicable. In any tort action brought against the owner or operator of a motor vehicle, a plaintiff may recover damages in tort for pain, suffering, mental anguish, and inconvenience because of bodily injury or disease only in the event that the injury or disease consists in whole or in part of:

(a) Significant and permanent loss of an important bodily function.

(b) Permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement.

(c) Significant and permanent scarring or disfigurement.

(d) Death.
Fla. Stat. § 627.7407
Application of the Florida Motor Vehicle No-Fault Law

This statute revives the Florida Motor Vehicle No-Fault Law, effective January 1, 2008, after the law was repealed on October 1, 2007. This statute requires personal injury protection coverage for motor vehicle owners. The statute recognizes that vehicle owners were not required to maintain personal injury protection coverage from October 1, 2007 to January 1, 2008.

4. Negligence, Other Torts and Contribution

Fla. Stat. § 624.155
Bad Faith

This statute provides a civil remedy in the event an insurer does not attempt, in good faith, to settle claims toward its insured.

5. Miscellaneous Statutes

Fla. Stat. § 627.4145
Readable Language in Insurance Policies

Effective for policies written on or after Oct. 1, 1983, this statute requires that every insurance policy written in Florida pass a readability test and lists the criteria a policy must meet to be deemed “readable.” The statute also lists types of policies to which the readability requirement does not apply.

Fla. Stat. § 627.4265
Payment of Settlement

In a case in which a settlement between a person and insurer has been reached, the insurer shall tender payment no later than twenty (20) days after such settlement is reached. If the payment is not tendered within twenty (20) days or another date agreed to by the parties, it shall bear interest at the rate of twelve (12) percent per year from the date of the settlement agreement.

Fla. Stat. § 627.7142.
Homeowner Claims Bill of Rights

After 90 days, insurers may not deny a claim based on undisclosed credit issues or cancel an insurance policy for insured’s personal credit information which was “publicly available.” The law also adds some provisions regarding the qualifications of neutral evaluators and umpires for appraisals.
### B. Florida Statutes of Limitations

<table>
<thead>
<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
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<tbody>
<tr>
<td>Specific Performance of a Contract</td>
<td>One year for an action for specific performance of a contract.</td>
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<tr>
<td>Fla. Stat. § 95.11(5)(a)</td>
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<thead>
<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
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<tbody>
<tr>
<td>Medical Malpractice</td>
<td>Two years from the time the incident giving rise to the action occurred, or two years from the time the incident should have been discovered with due diligence. In no event shall the action be commenced later than four years from the date of the incident or occurrence out of which the cause of action occurred.</td>
</tr>
<tr>
<td>Fla. Stat § 95.11(4)(b)</td>
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<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
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<tbody>
<tr>
<td>Wrongful Death</td>
<td>Two years for an action for wrongful death.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(4)(d)</td>
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<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
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<tbody>
<tr>
<td>Libel or Slander</td>
<td>Two years for an action for libel or slander.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(4)(g)</td>
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</tr>
<tr>
<td>Claim Type/Section</td>
<td>Statute Period</td>
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<tr>
<td>Bodily Injury due to Negligence</td>
<td>Four years for an action founded on negligence.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(3)(a)</td>
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<tr>
<td>Personal Property damage due to Negligence</td>
<td>Four years for an action founded on negligence.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(3)(a)</td>
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</tr>
<tr>
<td>Trespass to Property</td>
<td>Four years for an action for trespass on real property.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(3)(g)</td>
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</tr>
<tr>
<td>Fraud</td>
<td>For an action founded on fraud, four years, with the period running from the time the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence. In any event, an action for fraud must be begun within twelve years after the date of the commission of the alleged fraud.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.031(2)(a)</td>
<td></td>
</tr>
<tr>
<td>Breach of Contract not in Writing</td>
<td>Four years for an action on a contract not founded on a written instrument.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(3)(k)</td>
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<tr>
<td>Assault and Battery</td>
<td>Four years for an action for assault and battery.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(3)(o)</td>
<td></td>
</tr>
<tr>
<td>Malicious Prosecution</td>
<td>Four years for an action for malicious prosecution.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(3)(o)</td>
<td></td>
</tr>
<tr>
<td>Statutorily Created Liability</td>
<td>Four years for an action founded on a statutory liability.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(3)(f)</td>
<td></td>
</tr>
<tr>
<td>Rights not Otherwise Provided for</td>
<td>Four years for any action not specifically provided for.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(3)(p)</td>
<td></td>
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</table>
**Products Liability**  
Fla. Stat. § 95.11(3)(e),  
Fla. Stat. § 95.031(2)(b)  

Four years for an action founded on the design, manufacture, distribution or sale of personal property not permanently incorporated into real property. Under no circumstances may a claimant commence an action for products liability to recover for harm allegedly caused by a product with an expected useful life of ten years or less, if the harm was caused by exposure to or use of the product more than twelve years after delivery of the product to its first purchaser or lessee who was not engaged in the business of selling or leasing the product or of using the product as a component in the manufacture of another product.

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<thead>
<tr>
<th>Claim Type/Section</th>
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<tbody>
<tr>
<td>Contract in Writing</td>
<td>Five years for an action on a contract founded on a written instrument.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(2)(b)</td>
<td></td>
</tr>
<tr>
<td>Foreclosure of Mortgage</td>
<td>Five years for an action to foreclose a mortgage.</td>
</tr>
<tr>
<td>Fla. Stat. § 95.11(2)(c)</td>
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<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
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<tbody>
<tr>
<td>Bad Faith</td>
<td>As a condition precedent to bringing an action of bad faith, an insurer must have been given sixty (60) days written notice of the violation. No action shall lie if, within sixty (60) days after filing notice, the damages are paid or the circumstances giving rise to the violation are corrected.</td>
</tr>
<tr>
<td>Fla. Stat. § 624.155</td>
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| Minor’s Claims     | Except as to claims of medical malpractice, the statute of limitations does not begin to run until the minor reaches the age of majority. In any case, the action must be begun within seven years after the act or event giving rise to the cause of action. |
| Fla. Stat. § 95.051(1)(h) |               |
C. **Significant Florida Court Decisions**

1. **Supreme Court Decisions**

   a. **Insurance Coverage Decision**


   **Indemnification Payments Satisfy SIR**

   The owner of a residence the insured construction company built fell through attic stairs a carpentry subcontractor installed. The construction company’s liability policy was subject to a $1,000,000.00 self-insured retention (SIR). The SIR endorsement stated the insurer would provide coverage only after the insured exhausted the $1,000,000.00 SIR. In mediation, the construction company, its insurer and the carpentry subcontractor and its insurer agreed to a $1,600,000.00 settlement. The carpentry contractor’s insurer paid $1,000,000.00. At issue was whether the construction company’s insurer was required to pay the remaining $600,000.00. The construction company’s insurer argued that because the $1,000,000.00 payment originated from the subcontractor’s insurer, the SIR was not reduced. The Supreme Court held that because the construction company’s policy stated the retained limit must be paid by the insured, but did not specify where the funds must originate, the policy allowed the insured to apply indemnification payments from a third party toward satisfaction of its SIR.

   b. **UM/UIM Decision**


   **Breach of CME Provision Did Not Forfeit Policy**

   Insured was involved in an auto accident with an uninsured driver in 2006. A year later, the insured submitted a claim for regional sympathetic dystrophy, demanding $3,500,000.00 in damages. The insurer requested that the insured undergo a compulsory medical examination (CME) as required by her UM policy. The insured failed to appear at the exam and demanded the insurer agree that she would not have to submit to any other exams. The insurer refused and asserted that because the insured breached the CME provision of the policy, she forfeited any benefits under the policy. The Supreme Court held that breach of the CME provision did not result in forfeiture under the policy unless the insurer pleaded and proved actual prejudice.
2. Appellate Court Decisions

a. Insurance Coverage Decisions


Insureds Must Show General Contractor Expenses are “Reasonably Likely”

Homeowners claimed hurricane damage to their homes. The adjusters did not include in their estimates overhead and profit expenses. The insurer wrote to the homeowners explaining that the estimates did not include overhead, profits, etc., but when a contractor was hired and expenses incurred, the homeowners could forward the bill for review and reimbursement. The appellate court remanded to the trial court to determine whether the insured would be “reasonably likely” to incur general contractor overhead and profit expenses as part of their claim for damages.

*Maddox v. Fla. Farm Bureau Gen.*, 129 So. 3d 1179 (Fla. Dist. Ct. App. 5th Dist. 2014)
http://www.5dca.org/Opinions/Opin2013/090913/5D12-3577.op.pdf

Mother’s and Son’s Dog Bites Considered “Separate Occurrences”

Plaintiff and her son were injured by a dog bite attack in her boyfriend’s home. When the plaintiff attempted to loosen the dog’s grip on her son’s face, she was bitten in the process. The boyfriend’s home insurer paid $100,000.00 to the plaintiff for her son’s injury under the personal liability coverage. Plaintiff filed a complaint against her boyfriend for her individual injuries. The insurer argued it was not liable for any additional payments to the plaintiff because it had already paid out its $100,000.00 limits per occurrence and the dog attack was part of the “same occurrence” that caused her son’s injury. The court held that because the two injuries at issue had two separate causes as they resulted from two separate bites, each injury was a “separate occurrence.”

http://www.4dca.org/opinions/May%202014/05-21-14/4D13-178.pdf

Economic Loss Rule

The plaintiff, a medical debt collector, relied on the defendant to obtain liability coverage for their debt collection activities. The defendant hired a broker to procure the policy, but the policy did not include liability coverage for debt collecting. Lawsuits were filed against the plaintiff regarding their debt collecting activities, in which the insurance company denied coverage. Upon settling the underlying claims, the plaintiff filed suit against defendant and the broker for negligence. Broker claimed the plaintiff was barred because the statute of limitations had begun running when the plaintiff hired counsel for the underlying lawsuits. The plaintiff claimed that the statute of limitations did not begin running until after the underlying claims were settled. The court agreed with the plaintiff that the statute of limitations did not begin running until the
plaintiff had incurred damages, which was after the underlying suits had been settled or, if there are no underlying suits, when the right to sue expires.


**Burden of Proof in Standard All-Risk Policies**

In this case an insured sought coverage for property damage due to sinkhole activity under a standard all-risk policy containing an exclusion for property loss stemming from sinkhole activity. However, the policy also contained an endorsement for “Sinkhole Loss Coverage” at an additional premium. The court found that a policy holder under an all-risk policy only has to establish that a physical loss occurred in order to satisfy the requirement of the insuring agreement, and the burden shifts to the insurer to prove an exclusion applies. First-party, all-risk policies that contain an endorsement do not convert the policies into specified-perils policies, which require a higher burden of proof on the insured to prove the cause of claimed loss was not excluded. The court reasoned that if decided the other way would create an unintended obstacle to insured rights and undermine the fundamental purpose of an all-risk policy.


http://www.4dca.org/opinions/Aug%202014/08-20-14/4D12-3410.op.Rhrg.pdf

**Sworn Proof of Loss - Condition Precedent**

Insured’s property was damaged from decomposing bodily fluids that were being disseminated next door from his deceased neighbor. Insurer tendered payment to the insured, but denied coverage for personal property damage. Insured did not accept payment, and filed a complaint. Insurer moved for summary judgment because the insured failed to meet a condition precedent in the insurance policy that required the insured to file a sworn proof of loss within 60 days of the date of loss. Insured responded by arguing the insurer had waived the sworn proof of loss requirement by tendering payment to the insured. The trial court entered summary judgment in favor of the insurer.

On appeal, the insured argued that the Florida Supreme Court’s recent decision in *State Farm Mutual Automobile Insurance Co. v. Curran*, 135 So.3d 1071 (Fla. 2014), rendered the sworn proof of loss a condition subsequent rather than a condition precedent. However, the district court stated that a compulsory medical examination, which was at issue in *Curran*, was a request by the insurer to substantiate a claim already made by the insured. Therefore, it is different than a sworn proof of loss, which is clearly a condition precedent.
Cooperation Clause

The insureds owned residential property damaged by a hurricane. The policy required insureds to submit to an examination under oath (EUO). Accordingly, insured was examined under oath; however, he deferred almost entirely to the adjuster as to the type and extent of damages. Insured filed suit against insurer, and insurer moved for summary judgment, arguing the insured had deprived insurer of a meaningful EUO. The appellate court reversed the trial court ruling in favor of insurer’s summary judgment. The appellate court based its decision on the fact there was not a total failure to comply by the insureds, stating that where an insured cooperates to some extent, a fact question remains as to whether the condition is breached to the extent of denying the insured any recovery under the policy.

b. UM/UIM Decision


De Minimis Offer Does Not Constitute UM

Insured was injured in an auto accident caused by another insured driver. When the driver’s insurer made a de minimis settlement offer to the insured, the insured sought UM benefits under her own policy. The court held that because the driver had $50,000.00 in liability coverage and the insured’s damages from the accident were less than $50,000.00, the driver did not qualify as an uninsured or underinsured motorist. Accordingly, the insured could not bring an action under her own UM policy because her damages did not exceed the amount available under the at-fault driver’s liability policy.

c. No-Fault (PIP) Decision


Medical Provider Not Entitled to Further Payments After PIP Exhausted

Insureds required medical treatment as a result of injuries sustained in accidents. The insurers reduced the bills paid to one provider based on the Medicare Fee Schedule (Fla. Stat. 627.736(5)(a)(2)). The insurers continued to pay other providers who had been assigned PIP benefits until the insured’s PIP benefits were exhausted. The provider whose bills were reduced filed suit after the remaining benefits were exhausted. The court held the provider’s right to further payments was extinguished by the exhaustion of PIP benefits.
d. Premises Liability Decision

http://www.4dca.org/opinions/Jan%202014/01-15-14/4D12-3064.op.pdf

**No Duty to Make Landscaping Safe When Walkways are Present**

Patron attempted to cross a landscaped area to enter a store. Concrete walkways allowed patrons to cross the landscaping without stepping into the landscaped area, which included dirt, mulch, trees and grass. The patron was aware of the walkways, but instead crossed the landscaping through the dirt, mulch and trees. The patron was injured when he fell after catching his foot in a tree root. The patron sued, claiming the store failed to keep the premises safe and failure to warn of latent dangers. The court held the store had no duty to make its landscaping safe for walking when the store had already provided concrete walkways for patrons to cross the landscaping areas.

e. Other Significant Decisions

http://www.4dca.org/opinions/Mar%202014/03-26-14/4D13-947.op.pdf

**Policy Disputes Must be Resolved Prior to Appraisal**

Insureds filed a claim for damage as a result of a roof leak. The insurer denied coverage, citing multiple policy provisions, and repeatedly refused the insureds’ demands for an appraisal of the loss. The insureds filed suit for breach of contract and to compel the appraisal. The court held that policy/coverage disputes must first be resolved before an appraisal is appropriate.

http://www.3dca.flcourts.org/Opinions/3D12-1655.pdf

**Payment After Suit and Attorneys’ Fees**

Insured’s vehicle was found partially submerged in a canal under questionable circumstances. The insured submitted a claim to his insurer, which the insurer did not pay. The insured sued the insurer. Following the suit, the insurer made a payment to the insured vehicle’s lien holder for the pre-loss value of the vehicle, less the deductible. The insured then filed a motion for attorneys’ fees on the grounds that the payment was a confession of judgment based on Fla. Stat. 627.428. The court held that when an insurer voluntarily pays a disputed loss after suit is filed, the payment is considered a confession in judgment and Fla. Stat. 627.428 authorizes attorneys’ fees to be paid to an insured.
http://www.4dca.org/opinions/Oct%202013/10-30-13/4D12-257.op.pdf

No Duty to Defend a Workmanship Claim Under CGL Policy

A contractor was called to a customer’s home to repair an air conditioning unit. The customer paid for the work, but the next day, the air conditioner still did not work and the customer stopped payment. The contractor sued the customer for breach of contract and the customer countersued for breach of contract and failure to complete repairs in a workmanlike manner. The contractor notified its insurer of the insurer’s duty to defend. The court held that because the customer’s claim alleged the contractor’s workmanship was at issue, the insurer did not have a duty to defend because the claims were not within the coverage of the insured’s general liability policy.

http://www.4dca.org/opinions/Nov%202013/11-20-13/4D12-4456.op.pdf

Consent Order Admissible in Material Misrepresentation Case

Insured applied for homeowner’s insurance over the phone. The agent asked him several questions including whether, or not, he had a burglar alarm. The agent checked a box on the application indicating the insured had an alarm, but the insured denied saying he had an alarm. The insured home was destroyed by fire and the insurer denied coverage because it claimed the insured had misrepresented that he had a burglar alarm. At trial, the insured was allowed to present a consent order from the Florida Department of Insurance which stated the insurer was using unlicensed agents who were giving quotes “based on every available discount.” On appeal, the court held the insured was permitted to present this evidence to refute the insurer’s coverage denial based on his “material misrepresentation.”


Insurer Denied Immunity From Bad Faith Claims

The appellate court addressed whether the insurer was entitled to immunity from claims alleging bad faith. The trial court judge dismissed the insured’s bad faith claim, ruling that the insurer was immune from bad faith actions under Florida Statute 627.351(6)(s)(2) as a “quasi governmental entity.” The statute allows for immunity for the insurer, with 5 exceptions, including “willful tort.” According to section 627.351(6)(s)2, the insurer has a “duty to its policyholders to handle claims carefully, timely, diligently, and in good faith.” The court reasoned that a violation of such duty fell within the broad definition of a “tort.” Thus, the court allowed the condominium to sue the insurer for bad faith, provided the condominium proved its “cause of action, including the willfulness” of the insurer’s actions.
Statute of Limitations and Full and Final Payment

Insurer made payments for a claim involving damages from Hurricane Wilma, which occurred in 2005. The insurer issued payments in 2006, but neither payment was marked final or paid in full. The insurer denied the insured’s supplemental claim submitted in October 2010. The insured filed suit in July 2011, alleging a breach of contract regarding the 2010 claim. The insurer argued the five year statute of limitations had run. The appellate court ruled in favor of the insured, noting that because the insurer’s 2006 payments did not indicate payment was full and final, the insured was correct in alleging the breach of contract occurred in 2010. Accordingly, the statute of limitations had not run.

Sinkhole Statute Permits Insurers to Withhold Partial Payment

Sinkhole activity was found at the insureds’ property. The insureds’ policy contained separate sinkhole coverage. The insureds sued the insurer to compel appraisal over a dispute regarding the amount the insurer owed. The insurer argued that it could withhold partial payment for the subsurface repairs until the insureds contracted for the repairs based on the sinkhole loss settlement clause in the insureds’ policy and Fla. Stat. 627.707(5)(6). The court held the insurer was authorized to withhold payment until services were contracted for based on the statute. The court noted that because the statute’s language was incorporated into the policy, the insurer was allowed to exercise the holdback as the statute permitted.

3. Federal Decisions

Statutory Definition of “Structural Damage” Applies to Sinkhole Losses

Homeowners brought claim for sinkhole loss under homeowners policy. Insurer, pursuant to recent Florida statutory change regarding the definition of “structural damage” in connection with sinkhole losses, denied the claim. Homeowners sued for breach of contract. The district court found that statutory definition did not apply, and instead construed the policy language of “structural damage to the building” to mean “any damage to the structure.” The Insurer appealed. United States Court of Appeals for the Eleventh Circuit reversed, finding that the statutory definition of structural damage applied.
Duty to Indemnify - Business Purpose

Insured, president and sole architect for a business was involved in a motor vehicle accident, while on a quick day trip “to fill up time.” The insurance policy, which was taken out on insured’s business to cover the automobile, provided that the insurer would provide coverage only when the automobile was being used for the business. Accordingly, insurer denied coverage, alleging the insured was not using the vehicle for business purposes. The district court held that the vehicle was not being used in connection with business, and therefore, insurer had no duty to defend or indemnify. The court reasoned that because insured was embarking on a trip that was not in connection with his business, and using his cell phone to make personal calls immediately prior to the accident, he had departed from any business purpose to pursue his own personal interest.

Release is Sufficient Consideration

An insurer issued a property insurance policy to a condo association. In 2005, the association’s property was damaged due to Hurricane Wilma. The insurer agreed to pay over $1,000,000.00 to the association in consideration for a release from its insured. Six years later, the association informed the insurer that it disagreed with the settlement and argued the release lacked consideration because the money it received was only a partial payment and did not cover future damages the association incurred. The court held that regardless of the amount of the release, the release itself was sufficient consideration.

Pollution Exclusion

Insured owned a bar where decedent was killed due to a customer’s release of pepper spray. The insured’s policy excludes coverage for bodily injury stemming from pollutants. The district court, applying Florida law, held that the insurer did not have any duty to defend or indemnify because pepper spray is an irritant which is characterized as a pollutant.
Interline Brands, Inc. v. Chartis Specialty Ins. Co., 749 F.3d 962 (11th Cir. April 15, 2014)  

Illusory Coverage Doctrine

Plaintiff purchased a series of CGL policies, which contained an exclusion for violation of any statute that addressed transmitting any information. The plaintiff was sued regarding unwanted junk faxes in violation of a statute, and the defendant insurer denied coverage. The insurance company claimed the lawsuit fell under the exclusion. Plaintiff claimed that the exclusion clause was void because it was ambiguous and against public policy. The court in deciding did not closely follow the illusory coverage doctrine. The court found that, even though the exclusion clause is broad, the policy still provided extensive coverage and only excluded violations of a statute, ordinance, or regulation regarding “sending, transmitting, or communicating of any material or information.” The court reasoned that policies allowing “coverage for violations of law creates a moral hazard that could substantially increase insurance costs.”


Duty to Indemnify - “Your Work” Exclusion

Insured contracted with a commercial property owner to construct a fitness center to an already existing building. After completion of the construction, water leaked through the roof, windows, and doors, causing damage to the property. Accordingly, the property owner refused to release the final payment to the insured. Ultimately, insured agreed to settle with the property owner, and then requested insurer to contribute and reimburse insured for amount. Insurer mailed insured a check for a much lesser amount, and insured filed suit. The insurance policy stated that coverage was excluded on any property that must be restored or replaced because “your work” was incorrectly performed on it.

The appellate court held that insurer did not have a duty to indemnify insured because there was no evidence of damage to property other than the completed fitness center.

http://www.5dca.org/Opinions/Opin2014/071414/5D12-3048.op.pdf

Homeowner’s Ownership Interest

Insured and her insurer brought action against homeowners association’s commercial general liability insurer for declaratory judgment that it owed a duty to defend and indemnify insured in action for wrongful death of child in homeowners association’s swimming pool. The only issue was whether the insured had potential liability arising from ownership of the pool. The appellate court reversed the trial court’s ruling in favor of summary judgment for the insured. The appellate court held that although the insured was entitled to use the pool within the homeowners
association, the right to use property does not equate to ownership. Therefore, a material fact of whether insured had an ownership interest in the community pool still remained.


**Withholding Payments for Providers’ Fraudulent Claims**

The insureds were injured in a car accident in 2006 and assigned their right to receive PIP benefits to a medical provider in exchange for treatment. Subsequently, after learning the medical provider was submitting fraudulent claims, the insurer stopped paying the insured’s bills. However, the insurer was supposed to first obtain a proper medical report, prior to withdrawing payment, which they did not do. The trial court ruled in favor of the insured, holding that the insurer violated their duty to obtain a proper medical report prior to withdrawing payment. The appellate court reversed, stating that the insurer’s compliance with the requirement to obtain a report before terminating all PIP benefits is unnecessary, when an insurer seeks only to deny all claims by a fraudulent provider.


**Duty to Defend – Injury-in-Fact Rule**

Insured brought a bad faith action for a failure to defend against former insurer. The damage for which payment was sought occurred during insurer’s coverage period, but was not discovered until after insured had transferred their business to another insurer. The court adopted the “injury-in-fact” rule, which holds that an insurer’s duty to defend is triggered if the damage or injury occurred during the time of coverage, as opposed to being triggered when the damage is discovered or manifested.
D. **SIGNIFICANT CASES PENDING BEFORE THE FLORIDA SUPREME COURT**


**Whether Insurer Immune From Bad Faith Suit**

The Supreme Court will determine whether the insurer as a quasi-governmental organization is immune from liability on a bad faith claim under Florida Statute § 627.351.


**Whether Opposing Counsel’s Billing Records Relevant to Fee Multiplier**

The Supreme Court will decide whether the Florida District Court for the Fourth District erred when it determined that billing records were not discoverable for attorney’s fee hearing, absent a showing by the plaintiff.


**Concurrent Cause of Loss v. Efficient Proximate Cause**

The Supreme Court will resolve an apparent conflict between the Florida District Courts of Appeal regarding whether the concurrent cause of loss rule or the efficient proximate cause rule should be the rule in Florida in the first party coverage context. The efficient proximate cause theory states the rule that the fact finder will determine which peril was the most contributing factor to the loss, then looks to the policy. If the peril is excluded, there is no coverage. The concurrent cause of loss doctrine permits coverage whenever two or more perils contribute to a loss and the policy covers at least one of the perils.

These cases were pending at the time this summary was printed. To confirm whether the Supreme Court has issued a decision in any of these cases, we invite you to visit our website at [http://www.smithrolfes.com](http://www.smithrolfes.com).

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VIII. THE STATE OF WEST VIRGINIA

A. FREQUENTLY CITED WEST VIRGINIA STATUTES

1. General Considerations in Insurance Claim Management

W.Va. Code § 33-6-3
Insurable Interest Requirement for Property
No insurance contract of property shall be enforceable except for the benefit of persons having an insurable interest in the things insured. “Insurable interest” is defined as “any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.”

W.Va. Code § 33-6-14
Policy Provision Shortening Limitations Period
This statute prohibits policy provisions which mandate an action based on the policy be brought in a time period less than two (2) years from when the cause of action occurs.

W.Va. Code § 33-11-4(2)
Unfair Claims Practices
This statute prohibits the misrepresentation and false advertising of insurance policies.

W.Va. Code § 33-11-4(9)
Insurer’s Duty to Acknowledge Communications Regarding Claims; Investigation
An insurer shall not fail to acknowledge and act reasonably promptly upon communications with respect to claims. Insurers must also not fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

Within fifteen (15) days after an insurer receives notice of a claim, the insurer must pay or deny such claim.

W.Va. Code § 33-28-6
Outline of Coverage
No individual accident or sickness insurance policy shall be delivered or issued for delivery unless an outline accompanies the policy or subscriber contract in the case of a direct response insurance product, or is delivered to the applicant at the time the application is made in all other cases. The statute lists what an effective outline of coverage contains.

W.Va. Code § 55-2-13
Foreign Judgments and Decrees
This statute bars every action or suit upon a judgment or decree in another state or country if the laws of that state or country would bar such action or suit and the judgment or decree would be incapable of being otherwise enforced there.
W.Va. Code § 55-13-1
Declaratory Judgments

This statute gives the circuit and county courts of West Virginia the authority to declare rights, status, and other legal relations, whether or not further relief is or could be claimed.

2. Insurance Fraud

W.Va. Code § 29-3-12(a)
Responsibilities of Insurance Companies in Fire Loss Investigation

This statute states that any insurance company shall notify the fire marshal, if it has reason to believe, based on its investigation of a fire loss to real or personal property, the fire was caused by other than accidental means. The company shall furnish the fire marshal with pertinent information acquired during its investigation and cooperate with the courts and administrative agencies of the state, and the fire marshal, any assistant fire marshal, or any investigator under the fire marshal’s authority.

W.Va. Code § 33-6-7
Representations in Applications

All statements and descriptions made by an insured in an application for insurance shall be deemed a representation. A misrepresentation, omission, concealment of facts or incorrect statements may prevent recovery if it is fraudulent or material to either acceptance of the risk or to the hazard assumed by the insurer, or if the insurer, in good faith, would not have issued the policy or insured in as large an amount had the true facts been known.

W.Va. Code § 33-6-25
Proof of Loss Forms

Upon request of any person claiming to have a loss under an insurance contract, an insurer shall furnish forms of proof of loss. This statutory requirement does not include a responsibility for the completeness of such proof by the insurer.

W.Va. Code § 33-6-26
Claims Administration

Acknowledgment of the receipt of notice of loss or claim under a policy, furnishing forms for reporting a loss or claim, for giving information relative to a loss or claim, for making proof of loss, or investigating any loss or claim under any policy or engaging in settlement negotiations does not constitute a waiver of any provision of a policy or any defense.

W.Va. Code § 33-41-11
False Statements to Insurers

This statute deems false statements or representations by any person to an insurer to be a felony if the benefit sought is equal to or greater than $1,000.00 or to be a misdemeanor if the benefit sought is less than $1,000.00.
3. Automobile Insurance

W.Va. Code § 17D-4-2
Minimum Insurance Required
The statute requires motor vehicle insurance in the amounts of: $20,000.00 in case of bodily injury to, or death of, one person in any one crash; $40,000.00 in case of bodily injury to, or death of, two or more persons in any one crash; $10,000.00 in case of injury to, or destruction of, property of others in any one crash.

W.Va. Code § 33-6-29
Rental and Leasing Driver’s Insurance is Primary
The valid insurance providing coverage for the lessor of a motor vehicle for rent or lease is secondary. Recovery under the lessor’s motor vehicle insurance will not be permitted unless the lessee has exhausted the limits of all other insurance policies available to him and no consideration was paid on behalf of the insured vehicle.

W.Va. Code § 33-6-31(a)
Uninsured and Underinsured Motor Vehicle Coverage
No motor vehicle liability insurance policy shall be issued unless uninsured motor vehicle (UMV) coverage is provided therein.

The term “uninsured motor vehicle” includes motor vehicles as to which there is no: (a) bodily injury liability insurance and property damage liability insurance, (b) there is such insurance, but the insurance company writing the same denies coverage thereunder, or (c) there is no certificate of self-insurance.

W.Va. Code § 33-6-31(b)
Anti-Stacking Language Void
Anti-stacking language in insurance policies is void to the extent that such language is purportedly applicable to uninsured or underinsured motorist coverage, and an insured covered simultaneously by two or more uninsured or underinsured motorist policy endorsements may recover under all of such endorsements up to the aggregated or stacked limits of the same.

4. Negligence, Other Torts and Contribution

W.Va. Code § 33-41-12
Civil Remedies
This statute establishes civil remedies for an insured against an insurer.

5. Miscellaneous Statutes

W.Va. Code § 33-11-4(9)(h)
Payment of Settlement
No insurer shall perform, with such frequency as to indicate a general business practice, attempting to settle a claim for less than the amount to which a reasonable man would have
believed he was entitled based on advertising material accompanying or made part of an application.

**W. Va. Code § 33-29-5**
Readable Language in Insurance Policies

This statute requires that every life, accident, and sickness insurance policy written in West Virginia pass a readability test, and lists the criteria a policy must meet to be deemed “readable.”
### West Virginia Statutes of Limitations

<table>
<thead>
<tr>
<th>Claim Type/Section</th>
<th>Statute Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B.</strong></td>
<td></td>
</tr>
<tr>
<td>Libel, Slander, &amp;</td>
<td>One year for an action for libel, slander, and defamation.</td>
</tr>
<tr>
<td>Defamation</td>
<td></td>
</tr>
<tr>
<td>W.Va. Code § 55-2-12(c)</td>
<td></td>
</tr>
<tr>
<td>Torts of Bad Faith</td>
<td>One year for an action for torts of bad faith.</td>
</tr>
<tr>
<td>W.Va. Code § 55-2-12(c)</td>
<td></td>
</tr>
<tr>
<td>Assault and Battery</td>
<td>Two years for an action for assault and battery.</td>
</tr>
<tr>
<td>W.Va. Code § 55-2-12(b)</td>
<td></td>
</tr>
<tr>
<td>Bodily Injury due to Negligence</td>
<td>Two years for an action founded on negligence.</td>
</tr>
<tr>
<td>W.Va. Code § 55-2-12(b)</td>
<td></td>
</tr>
<tr>
<td>Personal Property Damage due to</td>
<td>Two years for an action founded on negligence.</td>
</tr>
<tr>
<td>Negligence</td>
<td></td>
</tr>
<tr>
<td>W.Va. Code § 55-2-12(a)</td>
<td></td>
</tr>
<tr>
<td>Wrongful Death</td>
<td>Two years for an action for wrongful death.</td>
</tr>
<tr>
<td>W.Va. Code § 55-7-6</td>
<td></td>
</tr>
<tr>
<td>Fraud</td>
<td>Two years after the right has accrued.</td>
</tr>
<tr>
<td>W.Va. Code § 55-2-12</td>
<td></td>
</tr>
<tr>
<td>Medical Malpractice</td>
<td>Two years from the date of the injury, or within two years of the date when the injury is discovered or reasonably should have been discovered, not to exceed ten years after the date of injury.</td>
</tr>
<tr>
<td>W.Va. Code § 55-7B-4</td>
<td></td>
</tr>
<tr>
<td>Product Liability Claims</td>
<td>Two years after the right has accrued.</td>
</tr>
<tr>
<td>W.Va. Code § 55-2-12</td>
<td></td>
</tr>
<tr>
<td>Claim Type/Section</td>
<td>Statute Period</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Breach of Contract not in Writing</td>
<td>Five years for an action on a contract not founded on a written instrument.</td>
</tr>
<tr>
<td>W.Va. Code § 55-2-6</td>
<td></td>
</tr>
<tr>
<td>Breach of Contract in Writing</td>
<td>Ten years for an action on a contract founded on a written instrument.</td>
</tr>
<tr>
<td>W.Va. Code § 55-2-6</td>
<td></td>
</tr>
<tr>
<td>Minor’s Claims – Claims of Insane Persons</td>
<td>The limitation for any minor’s claims does not begin until his becoming of full age. If an insane plaintiff is injured, the limitation period does not begin until plaintiff is found sane, not to exceed twenty years from when the right accrues.</td>
</tr>
<tr>
<td>W.Va. Code § 55-2-15</td>
<td></td>
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</tbody>
</table>
C. **SIGNIFICANT WEST VIRGINIA COURT DECISIONS**

1. **Supreme Court of Appeals Decisions**

a. **Insurance Coverage Decisions**


**Insurer’s Subrogation Rights**

Tortfeasor was in a motor vehicle accident with insured. The tortfeasor was covered under the vehicle owner’s policy and his own policy. Insured filed suit against tortfeasor without notifying her insurer. Vehicle owner’s carrier and insured’s carrier entered into arbitration for medical payments. Insured settled with vehicle’s insurer and the tortfeasor’s carrier and filed suit against her insurer for breach of contract, unfair claims settlement practices and bad faith. The trial court granted insurer’s motion for summary judgment. On appeal, insured contended summary judgment was granted to insurer before discovery was completed. However, the Supreme Court of Appeals held insured’s motion to continue trial and extend discovery deadlines does not satisfy the informal requirements of *Powderidge Unit Owners Ass’n v. Highland Properties, Ltd.* 474 S.E.2d 872 (W.Va. 1996) in that it failed to articulate any basis for the belief an extension would provide them with ‘discoverable material facts,’ in a reasonable time, which would provide a genuine and material issue, defeating summary judgment. Also, insured contends the court misapplied the “made whole” rule. The court held insurer had a contractual right of subrogation against the vehicle owner’s carrier, and by entering into arbitration, they were preserving their rights prior to statute of limitations having run. Further, the insured received proceeds from both the tortfeasor and vehicle owners policies, therefore, no reasonable fact-finder could find she was not made whole.


**Ambiguous Policy**

Injured was shot by an unknown assailant while a patron at a nightclub. The insured nightclub had a commercial general liability policy with insurer that contained exclusions for “Assault or Battery,” however; it also included an endorsement for “Limited Assault or Battery Coverage” limiting coverage to $25,000.00. The insurer filed a declaration of rights action requesting the court find the policy only provided up to $25,000.00 of coverage, inclusive of attorney’s fees. The trial court granted summary judgment to insurer. The insured and injured party appealed. Insured contends the exclusion regarding the monetary limit on insurer’s duty to defend is unclear and ambiguous. The Supreme Court of Appeals agreed citing the lack of a definition of “supplementary payments,” contradictory language, and that attorney and defense fees were not addressed directly nor did they expressly reduce the limits of insurance. Since ambiguous terms in insurance contracts are construed in favor of the insured, summary judgment was improper. Regarding the third party claim, injured contends the trial court erred in limiting coverage to
$25,000.00 by failing to analyze coverage from the standpoint of the insured for whether the injury occurred by negligence or an intentional tort. However, the court found that damages of which injured sought compensation fell within the “Limited Assault or Battery” endorsement, and affirmed the trial court’s limitation of damages to $25,000.00.


**Coverage**

Wife brought action against insurer when their insured hydroplaned into her husband, killing him. Wife contends in a declaratory judgment action the insured’s policy provides coverage for their insured’s negligence. Insured had been removed from the policy by his significant other after their separation; however, insurer never sent notice to insured. Seven days after the formal divorce, insured was involved in the action that killed the decedent. At issue was *W. Va. Code s. 33-6-36* which plaintiff contends obligates insurer to provide liability coverage since they failed to properly notify the insured. Insurer argues that insured and his significant other were not married long enough for the statute to apply. The trial court granted summary judgment to the wife. On appeal, the Supreme Court of Appeals determined the statutory language “the named insured or spouse covered by a motor vehicle liability policy for a period of two or more years” was ambiguous regarding whether it is referring to the existence of the policy or the marriage. The court construed the ambiguity to mean only the policy must be in effect for two years. Since there was an invalid cancellation of the policy, the policy was in effect, consistent with *W.Va. Code s. 33-6-36*, and coverage was afforded for the accident.

**b. Other Significant Decisions**

**Kenney v. Liston**, No. 13-0427 (W. Va., June 4, 2014)  

**Collateral Source Rule**

Injured was stopped at a traffic light when tortfeasor rear-ended him while intoxicated. Tortfeasor admitted culpability and the trial was bifurcated into compensatory damages and punitive damages. Prior to trial, the trial court denied tortfeasors motion *in limine* to limit the injured’s medical bills as they had been adjusted per agreements with the injured’s insurer and medical provider, citing the collateral source rule. At trial the jury returned a verdict not reflecting the discounts and write-offs as to compensatory damages and as to punitive damages it was revealed to the jury that tortfeasor carried $100,000.00 in liability insurance and he knew his insurer may have to pay the verdict, even if it exceeded the liability limit. The jury returned a punitive damages verdict of $300,000.00. Tortfeasor appealed arguing the court should not have applied the collateral source rule as to medical expenses discounted and it was an error to allow the jury to hear evidence suggesting additional coverage “may or may not” be available from tortfeasor’s insurance to pay the excess verdict. The Supreme Court of Appeals found the tortfeasor is held liable to pay the full amount of injured’s damages as amounts paid by injured’s insurer are protected among the “legion” of collateral sources and amounts discounted are
considered a benefit of the plaintiff’s bargains with his health insurer and medical provider. As to punitive damages, the court found defendant’s counsel “opened the door” with testimony regarding tortfeasor’s liability coverage and that the insurer could be faced with paying an excess verdict pursuant to Shamblin v. Nationwide Mut. Ins. Co. 396 S.E.2d 766 (W. Va. 1990)(holding when an insurer fails to settle when there was an opportunity to, resulting in the insured incurring personal liability, the insurer has prima facie acted in bad faith and may be required to pay any judgment exceeding policy limits). Further, jury instructions are the discretion of the trial court and they correctly discerned it would have been misleading to lead the jury to believe there was only $100,000.00 available coverage.


Unfair Claims Settlement Practices

June 30, 2005, parents brought an action against the school board and school board’s insurer for injuries resulting from falls on two separate occasions. On July, 8, 2005, W.Va. Code § 33-11-4a(a) took effect, prohibiting third-party lawsuits that allege unfair claim settlement practices. In 2009, the parents settled the actions against the school board, then sought discovery against insurer on the claims of unfair claim settlement practices. Insurer filed a motion for protective order, asking the trial court to prohibit discovery for any unfair claims settlement practices that occurred after parents filed the original complaint or the date the statute went into effect. The trial court denied insurer’s motion opining the statute only protects insurer from third-party lawsuits, not the discovery of evidence. Insurer sought a writ of prohibition which the West Virginia Court of Appeals denied, stating the statute only bars third party lawsuits, not first-party, but the point was moot because the action was filed before the statute went into effect. Further, since the statute only prohibits unfair claim settlement activities that occur with frequency to constitute a “general business practice,” the parents are entitled to discovery to establish the existence of a “general business practice.”


Attorney-Client Privilege and Work-Product Doctrine

Property owners filed a property damage action against tortfeasor after they caused a landslide. The insurer initially denied coverage, but when the property owners amended their complaint to remove the language regarding a landslide the insurer retained counsel for the tortfeasor, provided a defense, and ultimately settled the case with property owners. Prior to settlement, tortfeasor filed a first-party bad faith against insurer and insurer’s legal counsel. The tortfeasor propounded discovery on the insurer and insurer’s counsel and they opposed disclosure of documents based on attorney-client privilege, work-product doctrine and relevancy. Tortfeasor compelled discovery and the circuit court relegated to a discovery commissioner who recommended disclosure of several materials. On appeal, the insurer and insurer’s counsel sought a writ of prohibition regarding the discovery order. The Supreme Court of Appeals found
the attorney-client privilege applied to the coverage opinion letters because of the counsel-client relationship and there was no precedent that privilege was waived when an insurer relays a recommendation of the insurer’s counsel to an insured. The seminar and training documents sought by tortfeasor were protected because they reflected the legal opinions of insurer’s counsel solely for use of the insurer. In accordance with Rule 26(b)(3), the court held the billing records and retention agreement were not protected because they were not developed in anticipation of litigation and they did not include substantive references to the attorney-client privilege or reveal the mental impression of the counsel; further, they were relevant since they pertained to the tortfeasor’s claims that insurer’s counsel provided coverage denial opinions to provide insurer with defenses to the bad faith claims.

2. Federal Court Decisions


**Consumer Protection Act**

Attorney General filed complaint and petition for injunction against insurance company for violation of the West Virginia Crash Parts Act and Consumer Credit and Protection Act for requiring the usage of salvage/recycled parts when negotiating vehicle repairs without the written consent of the vehicle owners. Additionally, the complaint alleged the petitioning repair company failed to include written statements notifying motor vehicle owners that salvage/recycled parts were being used in their repairs. In turn, the insurance company and repair shop counterclaimed for declaratory judgment. Upon cross-motions for summary judgment, the trial court found the recycled/salvaged parts did not comply with statutory requirements and was violative of the Acts and granted summary judgment for the Attorney General. The Supreme Court of Appeals found the trial court failed to address the written intent of the legislature, and failed to recognize the statutory distinction between salvage/recycled parts and aftermarket parts; resulting in a greatly broadened application of the Acts. Finding that salvage/recycled parts were not expressly mentioned by the legislature, the court declined to extend any interpretation as to their meaning and determined the insurance companies were not in violation of the statutes for requiring salvage/recycled parts in negotiating vehicle repairs. Since the statutes were inapplicable, the court held the repair company did not engage in unfair or deceptive trade practices by installing salvage/recycled parts.


[http://www.ca4.uscourts.gov/Opinions/Published/131194.P.pdf](http://www.ca4.uscourts.gov/Opinions/Published/131194.P.pdf)

**Contingent Business Interruption Ambiguity**

The insured obtained two policies from insurers that provided coverage of contingent business interruption only for injury incurred by “direct suppliers, customers, or recipients [sic].” Insured utilized natural gas in the process of titanium in a foreign country. Insured’s provider of natural gas had a contract with another company who processed and extracted the gas and placed it in
the pipeline for insured’s provider to deliver. The pipeline exploded, and the host country prioritized the supply of natural gas to domestic companies, curtailing insured’s supply of natural gas, and subsequently its process of titanium. Insured filed a claim for contingent business interruption with insurers. Insurers denied coverage, stating the injury was not a result of a direct supplier, since the interruption was from the processing and extraction company, not the natural gas provider. Insured sought a declaratory action on coverage, and filed a breach of contract and bad faith action. On summary judgment, the trial court held the term “direct” and an endorsement providing coverage for damage to properties “which wholly or partially prevents the delivery of materials to [insured] or to others for the account of [insured]…” were both ambiguous, and granted summary judgment to insured for the declaratory action, and to the insurers for the bad faith action. On appeal, the 4th Circuit held the term “direct” was unambiguous, citing no relationship with insured and the natural gas processing and extraction company. Additionally, the endorsement was unambiguous since coverage was only triggered in the event of damage to a direct supplier, customer, or recipient. Since the natural gas processing and extraction company was not a direct supplier, and the plain language of the policy excluded coverage for anything except a direction supplier, coverage did not exist.


**Damages: Aggravation, Inconvenience and Prejudgment Interest**

The insured sought to recover damage for aggravation and inconvenience when, in a previous action, the insurer breached the insurance policy and refused to defend him against liability resulting from a lawsuit. The insured also sought an award of prejudgment interest from the insurer on the attorney fees incurred as a direct result of having to hire counsel to defend him. The district court rejected the insured's demands for recovery for both claims. On appeal, the 4th Circuit determined the insured is able to recover damages for aggravation and inconvenience as long as those damages are proven as available forms of consequential damages to insureds who have proven an insurer breached their duty to defend. The insured also argued his expenses incurred in defending against the lawsuit are similar enough to liquidated damage to be subject to prejudgment interest. However, the 4th Circuit affirmed the district court's holding the insured's liability for the fees were accrued as they occurred, and even if the attorney's fees were sustained as direct damages, the absence of liquidity was enough to remove them from prejudgment interest.
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http://www.insurance.ohio.gov

**Kentucky Department of Insurance**
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Frankfort, Kentucky 40601
(800) 595-6053
http://insurance.ky.gov/

**Michigan Department of Insurance and Financial Services**
611 W Ottawa Street
3rd Floor
Lansing, Michigan 48933-1070
(877) 999-6442
http://www.michigan.gov/difs

**Indiana Department of Insurance**
311 West Washington Street
Suite 103
Indianapolis, Indiana 46204
(317) 232-2385
http://www.in.gov/idoi/

**Florida Office of Insurance Regulation**
200 East Gaines Street
Tallahassee, Florida 32399
(850) 413-3140
http://www.floir.com

**West Virginia Offices of the Insurance Commissioner**
1124 Smith Street
Charleston, West Virginia 25301
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